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Chapter 1

CONTRACT MANAGEMENT AND POLICY DEVELOPMENT

Section 1: Fiscal Report

IPAVS is currently operating under Grant AID/pha-G-1128 which became effective on September 1, 1975. The termination date of the Grant has been extended several times by AID, and is now due to expire November 30, 1980.

IPAVS has also received incremental funding through the years and the total cumulative budget up to November 30, 1978 now stands at \$17,450,000. Subject to availability, AID may allocate additional funds for subsequent periods (Table 1.1).

Table 1.1: Incremental Funding History of Grant AID/pha-G-1128, September 1, 1975 to November 30, 1978

Funding Period	Amount
September 1, 1975 to August 31, 1976	\$ 1,500,000
September 1, 1976 to December 31, 1976	1,875,261
January 1, 1977 to April 30, 1977	1,574,739
May 1, 1977 to November 30, 1977	3,000,000
December 1, 1977 to November 30, 1978	9,500,000
TOTAL	\$17,450,000

Table 1.2: Grant AID/pha-G-1128, Budget and Expenditures Statement
From September 1, 1975 to November 30, 1978

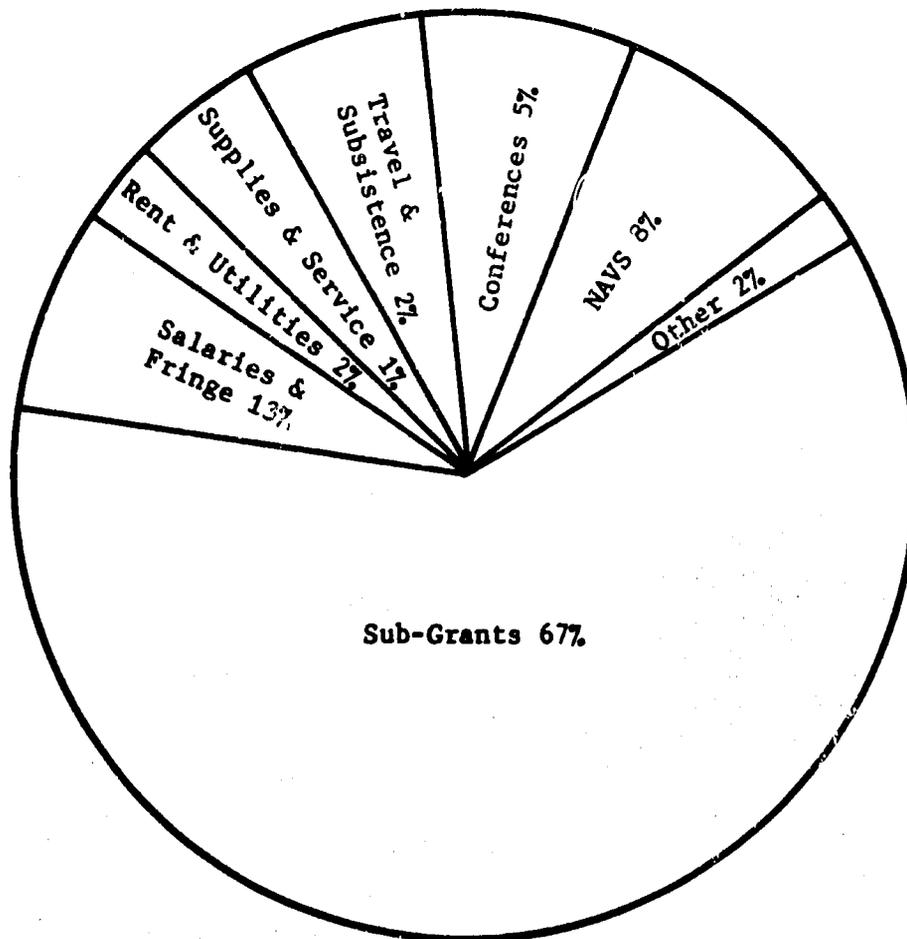
	Reallocated Budget 9/1/75-11/30/78	Actual Expenditures 9/1/75-11/30/78	Committed but Unexpended Funds as of 11/30/78	Free Balance as of 11/30/78
I. Salaries	\$ 1,298,997	\$1,298,997	----	----
II. Fringe Benefits	220,050	220,050	----	----
III. Consultants	52,405	52,405	----	----
IV. Rent and Utilities	214,729	214,729	----	----
V. Equipment and Furniture	65,072	65,072	----	----
VI. Supplies and Services	114,256	114,256	----	----
VII. Communications	91,953	91,953	----	----
VIII. Travel and Subsistence	232,390	232,390	----	----
IX. I&E	72,876	72,876	----	----
X. Conferences	544,080	537,180	\$ 6,900	----
XI. Sub-grants	13,407,494	5,128,362	2,627,060	\$5,652,072
XII. NAVS	1,077,536	598,655	274,627	204,254
XIII. Regional Offices	58,162	58,162	----	----
	<hr/>	<hr/>	<hr/>	<hr/>
TOTALS	\$17,450,000	\$8,685,087	\$2,908,587	\$5,856,326

It should be noted that the "Free Balance" as of November 30, 1978 was a substantial amount, i.e. \$5,856,326, which is approximately 34% of the total budget. This large free balance resulted because many sub-grant proposals processed by IPA VS were not awarded as of the cutoff of November 30, 1978. The reasons for the delay were either that insufficient information was provided by proposed sub-grantees, in which case additional information was requested by IPA VS, or that approval was not received from AID/Washington. In any event, most of these

funds had already been designated for sub-grant awards subsequent to November 30, 1978, and therefore will be carried over to the following fiscal year.

Figure 1.1 shows the percentage breakdown of total expenditures and commitments by budget category for Grant AID/ph-G-1128 through November 30, 1978. It is significant to note that the total amount expended and committed for program costs - conferences, sub-grants, and NAVSs - accounts for 80% of the Grant, with administrative costs a mere 20% throughout the grant period.

Figure 1.1. Percentage Breakdown of Total Expenditures and Commitments by Budget Category for Grant AID/pha-G-1128 (September 1, 1975 - November 30, 1978)



STAFFING AND ORGANIZATION STRUCTURE

There were twelve administrative/technical and seven support staff members authorized when Grant AID/pha-G-1128 was awarded on September 1, 1975. Because of the tremendous increase in IPAVS activities, the number of staff has more than doubled during the past year, so that as of November 1978, there were 43 authorized personnel (excluding regional office staff) which included 27 administrative/technical and 16 support staff members. IPAVS expects further growth in the number of its staff in the coming year.

The organizational structure incorporates a middle management level of functional area co-ordinators responsible for developing and managing the operations and work flow in their respective departments. The current IPAVS organizational chart is presented in Figure 1.2 and is now under review for modification in 1979.

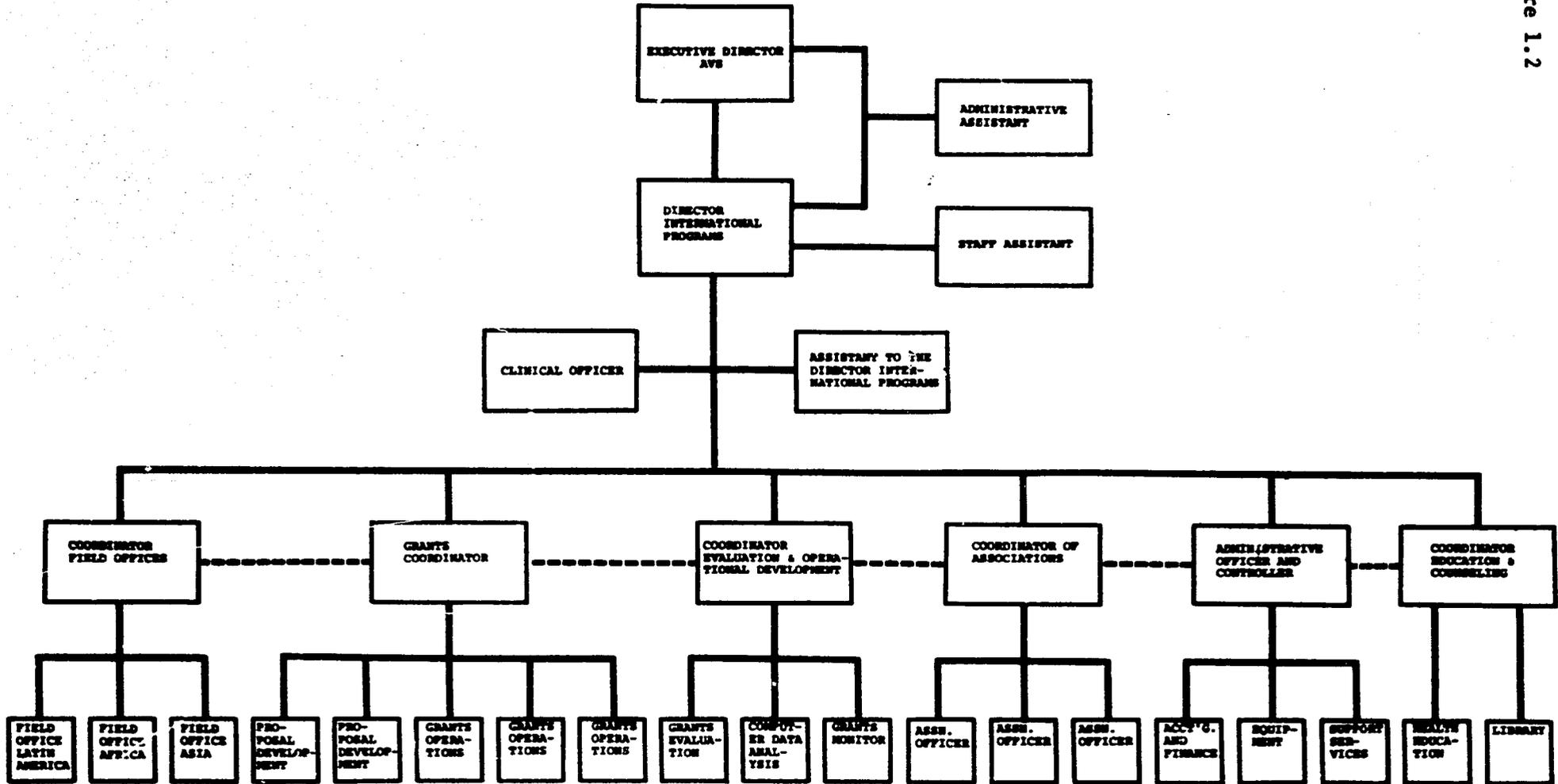
Section 2: Field Operations

REGIONAL OFFICES

The rapid growth in the number, scale, and complexity of IPAVS programs around the world has made it imperative that regional offices be established to co-ordinate activities and to give immediate attention to a variety of program and administrative needs in the field. Regional offices will maintain more effective liaison and co-ordination among sub-grantees, USAID Missions, local governments and other agencies. An important function will be the development of relationships with governmental and non-governmental leaders responsible for various kinds of development programs that are interrelated to the efforts to encourage acceptance and availability of voluntary sterilization programs.

IPAVS ORGANIZATIONAL CHART

Figure 1.2



The Asian regional office will be the first to begin operations. In October, 1978, the Government of Bangladesh permitted IPAVS to establish an office in Dacca which is expected to become operational in late spring of 1979.

A second Regional office, now in the planning stage, will be the African office, tentatively set for Tunisia. It is expected to begin operations in 1979. A third regional office is under consideration for location in Latin America.

REGIONAL REPORTS

Although the acceptance and availability of voluntary sterilization improved greatly during 1978, attitudes towards it in some regions of the world were less favorable than in others. In Asia, where attitudes are mostly favorable, a large number of sterilization procedures were performed. In Latin America services are becoming more available despite the fact that the legal status of voluntary sterilization is unclear in many countries of that region. In certain countries of the Middle East and North Africa, female sterilization services have been well received. During 1978, as in previous years, availability of services was lowest in Sub-Saharan Africa where approximately 1,450 female procedures were performed. Nevertheless, this was a significant increase from the 60 performed in 1977.

Africa and the Middle East

1978 was a crucial year for the development of IPAVS activities in the vast area of Africa and the Middle East. In general, it was a year of pioneering, planning, and laying the groundwork for voluntary sterilization activities in a region comprising over 60 countries.

IPAVS activities are expanding rapidly in this part of the world, in

spite of the many difficulties encountered. Numerous governments follow pro-natalist policies in various parts of the region. Communication difficulties and language barriers, infertility and subfertility problems, lack of adequate health care delivery systems, and high infant mortality rates are some of the major problems encountered along with the need for effective fertility management. Each country presents a unique set of circumstances requiring a specific country-by-country approach. Surgical contraception is still a very sensitive subject in Africa (vasectomy even more so than tubal ligation); therefore, careful planning is required to pioneer in these new directions of program development.

Three major priorities were considered for providing assistance to this region: (1) training of medical and paramedical personnel, (2) information and education activities, and (3) provision of equipment.

The demand for training in voluntary sterilization among health personnel is enormous, and award of sub-grants will lead to an increasing acceptance of surgical contraception among health professionals. IPAVS has been coordinating its training efforts with JHPIEGO and more cooperation is expected in the future. Although the concept of voluntary surgical contraception is spread via word-of-mouth in this region, misconceptions, lack of information, and cultural taboos are strong barriers to acceptance. It is the opinion of IPAVS that I&E programs, especially among health professionals, hold one of the most important keys to the expansion of voluntary surgical contraception services in Africa and the Middle East.

During 1978, twenty countries in the region were visited. Relationships were established between IPAVS and family planning associations, various medical and public health schools, local leadership and governments. Most visits were to develop initial contacts, and as such they concentrated on fact-finding and assessing basic needs for surgical contra-

ception programs. Nevertheless, 24 proposals were initiated, 14 service and training sub-grants and 26 small grants for equipment were awarded in the region. Altogether, a total of 15 countries in the region have, or are expected to have, IPAVS sub-grant support by 1979.

Because of their diversity, the Sub-Saharan Africa and North Africa/Middle East sub-regions are discussed separately below. Profiles of the two areas are provided, as well as an overview of IPAVS activities during 1978.

Sub-Saharan Africa:

In this least economically developed area, infant mortality is frequently above 200/1,000. Typically, a new-born African in the Sub-Saharan area can expect to live about 40-45 years. In several countries, per capita incomes are below \$100 annually. Health infrastructures are, in many places, either nonexistent or rudimentary; often there is hardly one physician per 60,000 people. Although fertility rates are extremely high in this part of the world, governments often follow pro-natalist policies that discourage the provision of family health services. However, in countries with the highest population growth rates in the world (some around 3% per year) family planning has become an issue of increasing concern. Paradoxically, high levels of fertility exist alongside high levels of infertility. But infertility in Sub-Saharan Africa does not obviate the need for fertility management programs; nevertheless, it can distract attention from the socio-economic problems inherent in rapid population growth and the fact that there is a pressing need for fertility management programs in Sub-Saharan Africa.

During 1978, IPAVS centered most of its groundbreaking efforts in this sub-region in the following countries:

Benin	Mauritius	Sudan
Ghana	Nigeria	Tanzania
Ivory Coast	Rwanda	Togo
Kenya	Senegal	Zaire
Liberia	Sierra Leone	Zambia

IPAVS staff visited most of these countries and identified a growing demand for surgical contraception. Interest in the development of national associations for voluntary sterilization was expressed this year by Nigeria, Mauritius and Sierra Leone. However, NAVS development is still in its infancy in this sub-region.

Many regional representatives of voluntary bilateral and multilateral agencies were visited by the IPAVS field representatives in 1978 in order to unify our common efforts and avoid duplication of efforts in Africa. Some agencies visited were WHO, UNFPA, IPPF, Pathfinder, FPIA, IFRP and PIEGO. These organizations were receptive to the work of IPAVS in the region.

IPAVS also developed relationships with key leaders from various Ministries of Public Health and Ministries of Planning. The unique public health benefits of voluntary sterilization were discussed with these government and health professionals. It is anticipated that many of the African leaders from these official bodies will attend the IPAVS Fourth International Conference in Korea.

Service Activity in Sub-Saharan Africa

The time is not yet ripe for large-scale service activity in Sub-Saharan Africa. Nevertheless, during the past year, 11 service proposals were initiated. Some examples of IPAVS activity in 1978 are listed by country. below.

Sudan: In this country IPAVS continued to support the Sudan Fertility Control Society who developed an in-service fertility and infertility training program at Soba Hospital. Other service grants are being developed in the Khartoum area.

Nigeria: A continuation sub-grant was awarded in late 1978 for a mini-laparotomy service and training project in Ibadan, and several other proposals are in various stages of development.

Zaire: In Kinshasa, a program to provide 1,000 voluntary tubal

ligations is expected to be funded during 1979 for five delivery centers. Voluntary surgical contraception as well as laparoscopic diagnosis of infertility will be offered. Two other projects are in development to provide services to rural areas of Zaire.

In keeping with the high priority given to all training efforts in Africa, IPAVS sponsored the training of several medical and non-medical leaders in the field of surgical contraception. In cooperation with PIEGO, IPAVS has been able to expand the number of trained personnel in the Sub-Saharan region.

Since Information and Education components were included in all service grants, I&E materials in French, Swahili, and Arabic were requested by sub-grantees. IPAVS will be assisting in these I&E efforts.

North Africa and the Middle East

The predominant culture of North Africa and the Middle East is of Arabic/Islamic origin. Health and economic conditions are poor, yet they are higher than in Sub-Saharan Africa. Infant mortality rates average around 130/1,000, life expectancy at birth is about 50 years, yet the high birth rates lead to a population growth of approximately 3% annually. In some countries there is only one physician per 14,000 population. Per capita incomes range from \$250 in Yemen to \$15,400 in Kuwait.

The Middle East and North Africa have long been areas of IPAVS involvement. During 1978, great strides were made in meeting current needs and in developing the resources necessary to satisfy future demands. In this region, female sterilization programs have been well received and tubal ligation services are becoming increasingly available in most countries here. A review of IPAVS involvement in the area during 1978 is given on the following page:

Tunisia: Government subsidies and the inclusion of voluntary sterilization services in the health and family planning program since 1974 have attracted tens of thousands of acceptors in Tunisia. It is estimated that, through 1978, over 50,000 women accepted surgical contraception. This represents 6% of all married women of reproductive age in the country.

IPAVS, USAID, UNFPA have jointly funded the Tunisian Office National du Planning Familial et de la Population (ONPFP) program to establish training centers for medical and paramedical personnel in family planning, including voluntary surgical contraception. The first ONPFP training center is being equipped and staffed with IPAVS support and will be the site for didactic training classes.

IPAVS has also provided support for the El Ariana Clinic which serves the rural South Tunis area. This clinic is becoming an international training center for physicians and paramedics, and programs in both French and Arabic have been scheduled for international trainees for 1979.

El Ariana is one of a planned nine regional clinical centers that will form the nucleus of a system to provide widespread service delivery at the local level, covering the entire country by the end of 1979.

IPAVS will establish a repair and maintenance center in conjunction with the Tunisian National Office of Population and Family Planning (ONPFP). Tunisia is becoming a model for the entire region in its efforts to provide voluntary sterilization services.

Egypt: The Egyptian Fertility Control Society (EFCS) with IPAVS support, continued to take the lead in promoting surgical contraception, not only in Egypt, but also in the entire Arab world. The EFCS developed a cadre of qualified personnel to provide services, and established well-equipped service centers so that high-quality services could be made easily available and accessible. An action-oriented project to coordinate a national training and service program in advanced techniques of fertility management is expected to begin operation in 1979.

Morocco: IPAVS was represented at two conferences in Rabat. These conferences were the French-speaking gynecologists' Fourth International Meeting and the XVII Congress of the Union of Arab Doctors. A special IPAVS exhibit was displayed at these meetings.

Syria: Gains in overcoming local difficulties concerning voluntary surgical contraception were made in Syria. During 1978, IPAVS identified indigenous leadership who established a national association in Syria.

Jordan: A major city branch of the Family Planning Association has committed itself to promoting voluntary sterilization through organized efforts.

Arab Republic of Yemen: This country demonstrated its interest in sterilization during the past year. Future site visits and the development of program activities are expected in 1979.

Turkey: Some progress was made towards improving the legal status of sterilization in this country, where it has been permitted in the past only for medical reasons. The Turkish National Fertility Association has undertaken this task, as well as the coordination of sterilization activities and research.

In summary, the potential for IPAVS-sponsored program activities appears to be great in this part of the world. Vasectomy is rare and countries are not yet ready to promote the method, but tubal ligation is widely accepted in many family planning programs. The Middle East and North Africa are playing a pioneering and influential role which will have an impact on the entire African continent.

Asia

The Asian region is a patchwork of national divergencies through which runs a common thread of shared concern among policy makers and program administrators for the ever-increasing populations whose pressures frustrate their efforts for socio-economic development and improvement of the quality of life.

The countries of South, Southeast and East Asia comprise over 55% (2.34 of 4.22 billion) of the world's population, yet geographically, they occupy less than 1/5 of the earth's total land area. Population in the region is increasing now at the rate of 1.9% per year, an implied doubling every 37 years if the course of events remains unchanged.

The age composition of the region was irretrievably altered and re-structured as a result of the high mortality rates suffered in World War II. Now, nearly 40% of the people are under 15 years of age, and



this figure is expected to increase from 2.34 to 3.49 billion by the year 2,000 A.D. in spite of the fact that infant mortality rates are very high (often above 100/1000) and life expectancy ranges from 40 to 60 years of age.

Per capita yearly income ranges from \$110 in Bangladesh to \$670 in South Korea, but for the region as a whole, the average is less than that of any other region except Africa and the Middle East. These incomes obviously reflect the severe constraints on financial resources available for socio-economic development.

Only 25% of the Asian region is urbanized and the vast majority of population resides in rural areas, isolated from the mainstream of urban economic activity. This factor complicates and frustrates even the most well-designed development efforts.

Although there are great differences among countries within the region -- not only in terms of the magnitude of their problems, but in the resources available for national strategies and programs -- virtually all national leaders of the region are committed to policies directed at lessening the population growth rate and socio-economic stagnation.

Perspectives

In almost every respect, Asia has been the pacesetter in advancing voluntary sterilization. Programs introduced and tested in Asia have often been models for other countries of the world. Official and public acceptance of voluntary sterilization has grown rapidly, and the majority of countries in the region have official policies and programs support voluntary surgical contraception, at least on a limited scale (see Table 1.3). Nevertheless, services are not yet universally available and in some countries, such as Bangladesh, the lack of effective managerial, logistics, facilities, and personnel infrastructure has almost defeated government plans to deliver services. In other countries, such as Thailand, where services have been incorporated into the mainstream of health services, the existing delivery system is itself proving inadequate to fulfill the demand.

Even in those countries with official policies and active programs, there is presently a limit -- from one cause or another -- to the ability of existing institutions to provide services. The need is now to look beyond simple service delivery via narrow health channels, to broader strategies that create new channels and modify old ones. Since the overwhelming majority of the population in need of services

Table 1.3. Status of National Voluntary Sterilization Policies and Programs: Asia 1978

	No official program; little or no services	No official program; but services permitted or encour- aged in government facilities	Active government service program
No stated policy or negative policy	Bhutan (?) No. Korea (?) Burma Kampuchea Laos (62.9)	Malaysia Vietnam (?) (62.2)	
No stated policy, but government facility permits/ approves	Afghanistan (17.3)	*Pakistan (?) *Indonesia (?) (217.0)	
Official policy			*Bangladesh, So.Korea *India *Nepal *Sri Lanka *Philippines *Singapore *Thailand, China People's Rep. Hong Kong (1812.6m)

- * Countries with ongoing IPAVS support
- ? Official status of voluntary sterilization unknown, unclear or in stage of transition
- () Figures in parentheses indicate cumulative population of countries in each cell in millions

is rural, every approach must look to new and innovative ways of bringing services to the people. Planners need to develop more flexible, extensive and penetrating systems that reach the often isolated majority residing outside of the urban networks.

Future Strategies and Options

Several programmatic constraints are obvious, as well as common, to all countries within the region: inadequate financial resources and trained manpower; inadequate numbers of health facilities; misconceptions, fears, rumors, inadequate information about the nature of voluntary sterilization in general; cultural norms favoring large families, and in some countries, religious and political barriers (although these are gradually relenting).

Demographic trends, population and socio-economic characteristics, and the presence or absence of a national policy/action program are basic considerations in any practical approach to strategy and program development for the region. Options that can be adopted flexibly by IPAUS during the coming year will include as top priority the "ruralization" of its efforts, such as:

- a) establishing and strengthening rural branch clinics of the voluntary, non-governmental agencies;
- b) providing mobile surgical team capability where existing health institutions do not reach populations;
- c) supporting government and non-government agencies in training medical and paramedical personnel from rural areas;
- d) providing equipment to and developing dedicated space in rural governmental health facilities;

Community-Based Development. National governments face many difficulties in translating policies into action and transferring the action programs developed in the urban centers to the rural village level. Conversely, rural villagers are most in tune with their local problems

and constraints and are eager to control programs which affect them directly. Assisting grassroots efforts will work both to meet national socio-economic development objectives and to satisfy the local desires and needs. Thus, IPA VS will encourage and support grassroots, community based efforts which may include;

- a) involving volunteers and local leaders within local branch activities of non-governmental agencies, especially NAVSs and FPAs;
- b) training local volunteers and other personnel to conduct local information and education and door-to-door recruitment;
- c) providing continuing support and reinforcement to acceptors in rural areas to encourage word-of-mouth motivation e.g. via follow-up and acceptor clubs.

Technological Adaptation and Training. The lack of sufficiently trained medical personnel will demand intensive attention in order to provide the technology in rural areas where medical personnel is scarce and overburdened. This may include:

- a) training rural physicians in simple techniques, especially mini-laparotomy and vasectomy;
- b) training auxiliary support staff to assist physicians to relieve the burden on physicians;
- c) studying the feasibility of training paramedical personnel to perform sterilization surgery.

Institutional Development. Present government institutions are generally inadequate to service all the demands. Further, they often lack the managerial capability to effectively implement programs.

- a) arrange and provide consultative technical assistance to governments in improving their managerial, logistics and supplies and infrastructures;
- b) continue to assist in developing and strengthening repair and maintenance institutions;
- c) continue to support the development and strengthening of non-governmental, voluntary institutions to complement and supplement the activities of government;

- d) study the feasibility of establishing regional training centers for various types and levels of personnel involved in surgical contraception programs;
- e) stimulating IPAVS sub-grantees to initiate small pilot demonstration projects in integrated approaches;
- f) tapping other development sectors, (i.e. industry, agriculture, education, military, commercial) to engage in information and education programs for voluntary sterilization;
- g) encourage and cooperate with governments in developing and adopting socio-economic and population development policies which explicitly include voluntary sterilization as a component.

Information and Education and Information Exchange. For both the individual and governments, the key to making rational decisions is the ready availability of adequate information. From a regional viewpoint, IPAVS will supplement its worldwide I & E program in the following ways:

- a) supporting programs which develop community-based information and word-of-mouth communication about voluntary sterilization;
- b) supporting counseling and counselor training programs in service facilities;
- c) selective support of mass media programs where they are feasible and permitted and where not already implemented by governments;
- d) encouraging exchange of information within the region via regional conferences and selected study tours for program policy makers and administrators

Inter-Sectoral Involvement and Linkage. Advancement of family planning and voluntary sterilization are inextricable part of the total socio-economic development process and must be advanced in tandem with it. In spite of the limits on IPAVS' resources that go to support comprehensive development approaches, IPAVS will pursue many avenues in the region to support voluntary sterilization's linkage with other development programs, such as:

- a) encouraging the provision of basic health service in volun-

tary sterilization clinics, including immunizations, physical screening, nutrition and sanitation education

- b) identifying other donor agencies with more flexible resources and encouraging them to support health, nutrition, sanitation and education components of IPAUS funded projects.

These strategies are idealistic and ambitious, but they reflect a recognition of the considerable advancement beyond the initial seeding efforts of five years ago. The Asia region, by contrast with Africa or South America, has graduated to a higher level of program development because of its past efforts. The challenge is greater now because the limits of existing institutions and systems are being reached.

The need for IPAUS to respond to this challenge are correspondingly great and IPAUS will need to move in the near future toward developing the technical assistance resources and capability to meet the varied and complex demands of the region.

Europe

IPAUS involvement in Europe has been limited due to restriction on the use of grant funds in developed countries. In 1977, the International Project provided funds for a survey in France to study the attitudes of French physicians toward voluntary sterilization. The results, published in 1978, showed that the majority of the physicians approved of, and had practiced, voluntary sterilization. The French Association for the Study of Sterilization continues working to generate a more favorable public opinion toward sterilization.

The status of voluntary sterilization in Europe varies greatly from complete accessibility of services, with little or no cost to the individual, to highly restricted availability of services. Since the legal status of voluntary sterilization is still unclarified for the most part, the procedure is technically regarded as a "criminal" act of mutilation. Although this construction is officially maintained on the books, it is not applied in practice since it is widely

accepted by general consensus.

Sterilization is technically illegal except for therapeutic reasons in Malta, Greece, Hungary, Italy, Spain and Portugal. IPAVS has received funding proposals from both Portugal and Italy. Portugal has applied for a grant to conduct a laparoscopic sterilization program for women of lower socio-economic status. Services would be provided free of charge and the salaries for the doctors and nurses would be paid by the Portuguese government, a sure sign of both official and public attitudinal changes. The proposal from Italy includes service, training, and Information and Education components.

In Yugoslavia, highly restrictive laws are becoming more liberal. Austria has firmly declared that sterilization is "not against good morals," and in the German Federal Republic, female sterilization has become increasingly popular since the 1976 Federal Court decision upholding the legality of voluntary sterilization. Male sterilization, however, is still rare in the Federal Republic.

In Eastern Europe and the U.S.S.R., all procedures are rare, and female sterilization can be obtained only in exceptional cases, such as that of multiparous women with tuberculosis. Poland, Romania, and Switzerland have no laws against male or female sterilizations performed by medically-skilled persons, and Norway and Czechoslovakia both provide a review process before each procedure is authorized.

Denmark, in 1973, and Sweden, in 1976, implemented liberalized laws, and sterilization is permitted upon request in Austria, Finland, Iceland, and Sweden.

In Great Britain, general practitioners perform vasectomy and the majority of tubal ligations are performed in government hospitals. Operations are state supported under the National Health Service and are free of charge.

Ireland has a pro-natalist policy, and female sterilization is almost unobtainable. Abortion and sale of contraceptives are illegal, but because there is no specific law governing vasectomies, physicians may perform the procedure in their offices.

Latin America

The present population of the Latin American region as a whole is approximately 340 million, and the rate of natural increase is 2.7% per year, second only to Africa. This high rate is the result of a low death rate of 9 per thousand coupled with a birth rate of 36 per thousand. By the year 2,000, the population of Latin America is expected to reach 606 million people.

It is traditional to divide Latin America into the sub-geographical regions of Central America, South America, and the Caribbean. South America is the largest sub-region in area and in population. With its natural rate of increase now at 2.5%, its present population of 228 million people will increase to 389 million by 2,000 A.D.

Central America, the second largest sub-region in physical size, is expected to double its population in 21 years due to its 3.3% rate of natural increase, the highest of the three sub-regions. The birth rate in Central America is 42 per thousand and the death rate is 8 per thousand. If this rate prevails in the near future, the Central American population will reach 175 million by 2,000 A.D.

The islands of the Caribbean have the lowest rate of natural increase (2% per annum) and a present population of 28 million people. The population will double in 35 years to 44 million by 2,000 A.D. Birth and death rates are 29 and 8 per thousand, respectively.

Economic Characteristics. The Latin American region is different from

many other regions of the developing world in a singularly significant aspect: 40% of its population reside in urban areas . Latin America is characterized by huge cities ringed by squatter shanty towns, a result of continuing, heavy migration to the cities by the rural poor seeking better opportunities.

The cities, under pressure from their growing migrant populations, are facing multiple problems, not the least of which is the provisioning of adequate water and power. Mexico, for instance, provides 20% of its national electrical power output just to pump sufficient water up to high altitude Mexico City. Throughout Latin America, an inadequate urban industry is unprepared to absorb the large number of rural migrants who are untrained and inexperienced. Even an adequate industrial base requires a level of education and technical training unobtainable in rural communities. Thus, the Latin American governments are faced with the twin problems of encouraging industrialization and raising educational levels. To encourage industrialization where there is still a very low level of literacy and technical expertise means that unemployment and underemployment rates will be very high.

Rural overcrowding and its corollary problems are as common in Latin America as in other developing world regions. Since only 30% of the world's land area is arable, the worldwide decline in farmland is having a direct, often drastic effect on the Latin American peasant. For a variety of reasons, more land is removed from food production each year than is reclaimed for it. The result in many areas is that there are more people per square acre than the land can sustain or the economy can employ. In Latin America, fights over land have erupted and peasants have seized outlying acres of large farms to claim as their own. Efforts to oust them have resulted in bloodshed and bitterness. The flight of the rural peasant to the cities is often a search for a way out of the impasse, yet for the hopeful migrant, urban life may offer little more than overcrowding urban-style, poverty, malnutrition, and disease.

Health

Compared with other developing regions, Latin America enjoys a relatively high level of health care as a whole. Infant mortality, often used as an index of the health status of a population is 84 per thousand children under one year of age. Only Honduras, Haiti, Nicaragua, Bolivia, and Brazil have infant mortality rates above 100. (Bolivia, the highest of all, has a rate of 157 per thousand.) The South American sub-region has a infant mortality rate of 98, almost 30 per thousand higher than the other sub-regions. Africa, as a contrasting example, has an infant mortality rate of 147 for the entire region, with no one country above 100.

Education and Religion

Educational level and religious convictions are the two factors most commonly considered to be the key to an individual's family planning behavior. Although such behavior is highly complex and many other factors contribute to it, it is thought now that the educational level is more significant in the individual's decision-making process than is religious conviction. Education is a weak social area in almost every Latin American country, and ignorance of sex coupled with lack of information about contraceptive options leave the poorer classes with little alternative in their fertility management. The wealthy classes who can afford private physicians, however, have easy access to new contraceptive technologies. The poor have made widespread use of clandestine abortion.

Since many Latin American families, of necessity, view their children as immediate economic assets in an often desperate and impoverished life, education is a luxury they cannot "afford." When a child becomes physically strong enough to contribute in some measure, however small, to the family's meagre income, allowing that child to attend school would be a serious economic hardship in an already precarious existence.

Forty-two percent of the Latin American population is under 15 years old and 4% is over 65, a dependency ratio of 54. This means that the burden of supporting 100% of the population would be borne by 54% of the population that comprises the 16-64 age group, if most children were allowed to complete the 9th grade.

The governments of Latin America are hardly unaware of the gravity of such a situation, yet religious influence in the attitudes and actions of governments has been a strong constraint, in many cases, against the development of family planning programs. Religious influence has been complex and multi-layered. At the local levels, the Church has historically refused to permit sex education and dissemination of birth control information in the belief that it is helping to maintain moral standards and prevent premarital sex. At national levels, the Church has had a chilling effect on issues of family planning. As a result of the encyclical *Humanae Vitae*, issued by Pope Paul VI in 1968, many Latin American governments became fearful and cautious, and some reacted strongly against measures intended to promote contraceptive availability. These actions have hindered the work of medical groups seeking to provide contraceptive services to the poorest sections of the population. Nevertheless, headway has been made by the family planning pioneers -- Mexico is a notable example of a complete change of attitude -- and IPAVS will continue to support efforts to establish voluntary sterilization services throughout the Latin American region.

The Machismo Factor

Machismo has long been cited as a strong influence on the Latin American male's behavior patterns, and is considered the psychological characteristic that most hinders acceptance of male sterilization. To fully understand machismo and its present and future roles in family planning promotion in the region, it is important to consider the history of militarism and revolution that has occurred in most

Latin American countries. Wars of independence in most of the region were followed by periods of anarchy and guerrilla warfare more cruel and longer than the wars of independence themselves. Several generations of men who should have been laborers spent their lives and soldiers and fighters. Their extreme mobility and adventurous spirit were not compatible with the establishment of secure family units. Their lives were spent affirming their virility, in battle as well as in their relationships with women. Once ingrained, such a spirit left its traces in the psychology of several generations. Although it is still evident, and a hindrance to the promotion of male-oriented contraceptive technology, the "machismo" attitude is slowly fading as knowledge and information about family planning have become more widely disseminated.

It is the task of a well-designed I and E programs now to re-direct the machismo spirit into a desire to be proficient in the use of contraception so that men can then take pride in controlling nature rather than being controlled.

FIELD PHYSICIANS

IPAVS added to its staff in 1978 a field physician (obstetrician/gynecologist) to assist IPAVS-sponsored clinics around the world in providing and maintaining quality medical services. The physician will assess the facilities, equipment, delivery of services, and the quality of surgical procedures performed in order to ensure that all facilities and procedures meet IPAVS standards. He will also assess physician and paramedical training programs, offering assistance and technical advice as needed.

The field physician has begun drafting recommendations for the development of new IPAVS medical policies.

Chapter 2

PROGRAM DEVELOPMENT

Since the IPAVS worldwide program is accomplished through awards of funds (sub-grants) to various types of professional groups and institutions who, in turn, develop and implement voluntary sterilization programs in their own countries, a proposal review and program development process is necessary to ensure productive and useful projects. Sound programmatic planning is essential in the initial stages of a proposal's development, and IPAVS often provides extensive assistance to potential sub-grantees so that program objectives are clearly identified and the scope of the proposed program is carefully delineated.

Section I: Proposal Activity

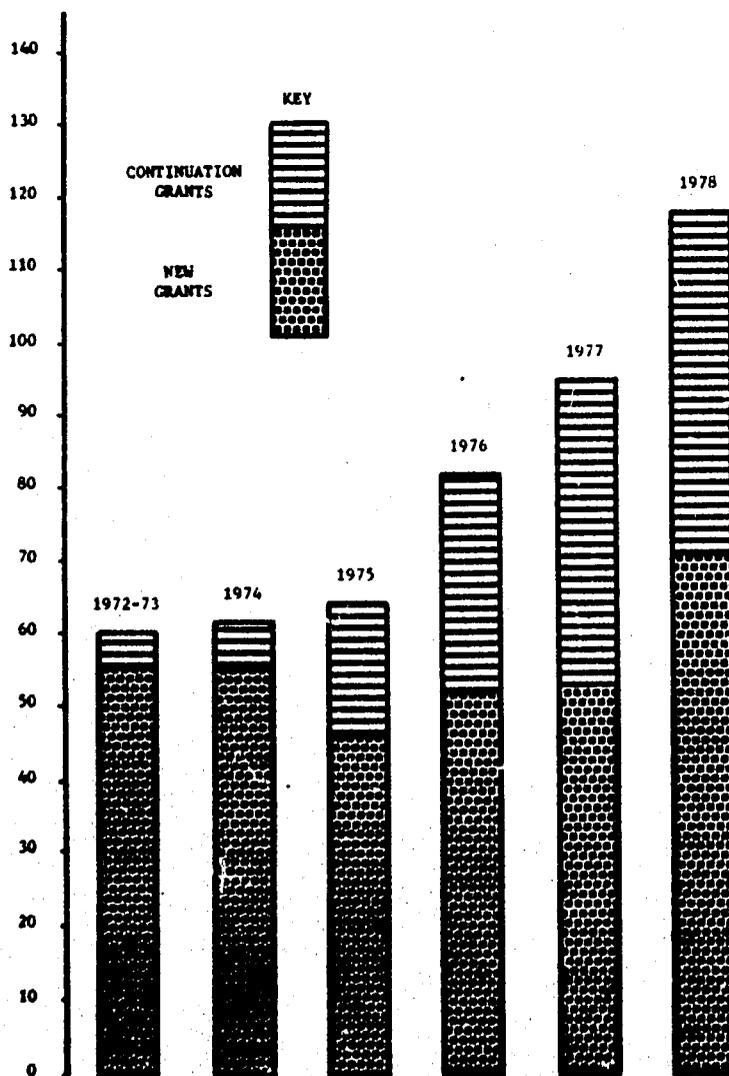
The Proposal Development Section handles requests for IPAVS assistance and is responsible for aiding the applicant in developing a sound and viable program which will meet the sub-grant funding requirements of AID. Proposal activity has increased steadily since 1972-3, as can be seen from Figure 2.1.

Table 2.1 summarizes proposal activity in 1978. The steep increase in the third quarter is possibly due to the fact that many recipient agencies prefer that sub-grants become effective on January 1st. It is to the credit of IPAVS' efficient staff and its streamlined management system that proposal development activities can respond to such a highly variable, but always demanding, schedule.

Table 2.1: Proposals Received in 1978, By Quarter

	<u>Jan.-March</u>	<u>Apr.-June</u>	<u>July-Sept.</u>	<u>Oct.-Dec.</u>	<u>Total</u>
No. of Proposals Received	18	26	48	25	117
New	(13)	(20)	(23)	(16)	72
Continuation	(5)	(6)	(25)	(9)	45

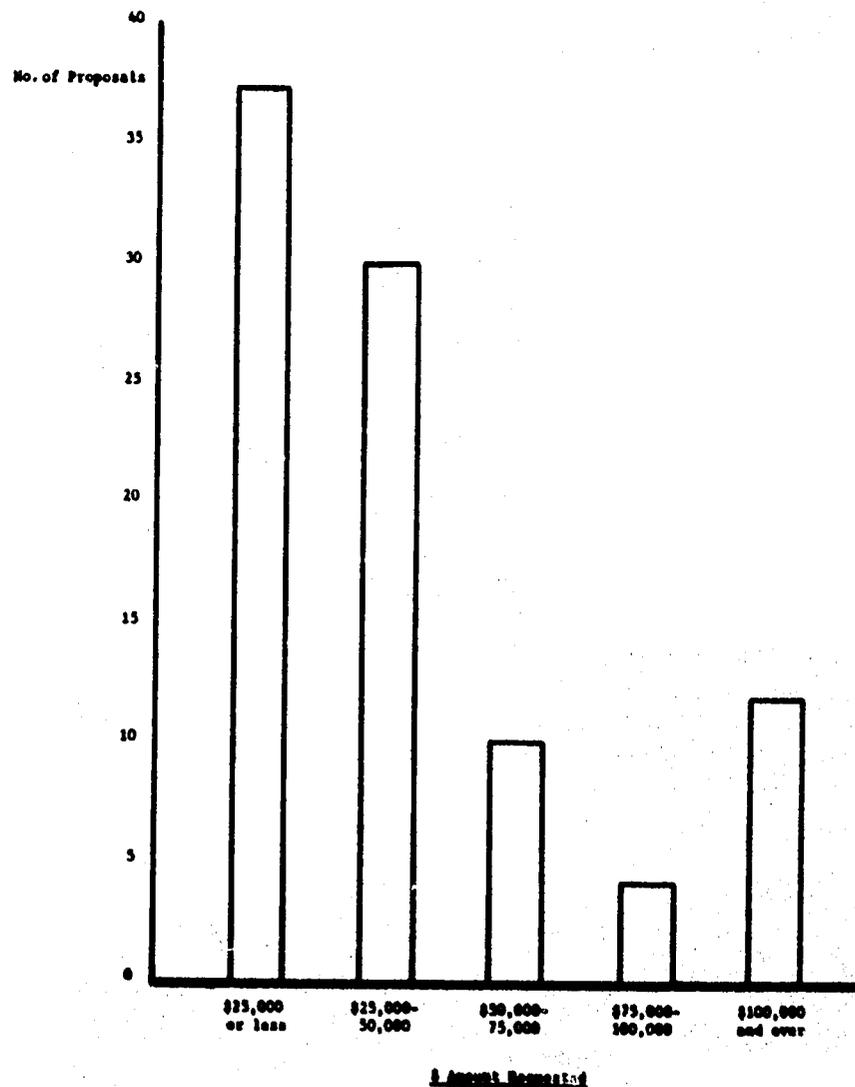
Figure 2.1 Growth In IPAVS Proposals by Year



PROPOSAL BUDGETS

During 1978, 101 proposals that included budgets were received for a total funding request level of \$7,228,177. There was much variation among the proposals in the amount of IPAVS funds requested. The mean amount of funds requested was \$72,812, the median amount was \$34,215. The smallest request was \$2,495 and the largest was \$649,959 giving a range of \$647,464. Figure 2.2 shows the distribution of budget figures for proposals received in 1978:

Figure 2.2 Funding Level Requested in Proposals Received During 1978



In 1978, an increasing number of proposals had equipment, training and Information & Education components, a reflection of IPA VS efforts to develop well-rounded, comprehensive programs. As a result, budgets tended to be larger than ever before. IPA VS has been quick to encourage sub-grantees to provide technical expertise at the local level to administer these many faceted sub-grants.

GEOGRAPHIC DISTRIBUTION

Table 2.2: Geographic Distribution of Proposals Submitted by Year

REGION	1972-73	1974	1975	1976	1977	1978	TOTAL
East Asia	21	20	26	24	29	24	144
South Asia	0	8	11	23	26	25	93
Middle America	12	9	9	13	16	23	82
South America	14	12	9	7	9	5	56
Africa	3	8	4	7	4	25	51
Middle East	6	2	2	3	6	2	21
Caribbean	3	1	2	6	2	7	21
Europe	0	1	0	0	2	5	8
North America	2	0	1	1	1	1	6
Oceania	0	1	0	0	0	0	1
TOTAL	61	62	64	84	95	117	483

The following trends can be observed from the foregoing table:

1. The number of proposals received in 1978 from Africa (25) is equal to the number received during the previous six years. This has exciting implications for IPA VS and indicates an opening of the door to voluntary sterilization activity in a region where availability of services is generally highly restricted.

2. The level of requests from South America declined to a low point in 1978 when only five proposals were received. This decrease in voluntary sterilization activity is a result of the political situation in this region.
3. Requests from East Asia and South Asia have remained fairly constant over the past few years and these regions continue to be the main centers of proposal activity.
4. Proposals from Middle America, after experiencing a slight decline in 1974 and 1975, increased from 1976 to 1978. The largest increase is seen between 1977 and 1978, and is calculated at 44%.
5. Although the number of requests received from Europe in 1978 (3) is equal to the total received during the previous six-year period, the numbers are so small as to be statistically insignificant. Nevertheless, the fact that these requests are coming from countries in which religious considerations do not favor the acceptance of voluntary sterilization (Italy, Portugal, and France) indicates that inroads are being made in increasing the acceptance and availability of voluntary sterilization in underserved areas.
6. The small number of proposals received from the Middle East during 1978 was disappointing. A possible explanation would be the political instability of many countries in that region. IPAVS hopes that there will be more voluntary sterilization activity in the Middle East during 1979.
7. Oceania and North America continue to be the regions of lowest IPAVS involvement.

STATUS OF PROPOSALS RECEIVED DURING 1978

The status of the 117 proposals received in 1978 is revealed in the following table:

Table 2.3 **Status of Proposals Received at IPA VS during 1978**

	<u>New Proposals</u>	<u>Continuation Proposals</u>
Awarded	9	10
Rejected	3	2
Forwarded to AID	12	18
In Process at IPA VS	47	14
On Hold	1	1

Of the three new proposals rejected, one was rejected because of AID/Washington's political considerations, one failed to receive the necessary approval from the International Committee because of programmatic considerations, and the third was withdrawn by the applicant because in-country approval was not obtained. The two continuation proposals that were not funded were rejected by IPA VS because of poor performance during the previous grant year.

The large number of new proposals in the developmental stage at IPA VS (61) resulted from the unusually high influx of proposals during the third quarter of 1978.

Continuation proposals have precedence over new proposals, so that interruption in funding from one grant year to the next may be avoided. As a result, the majority of continuation proposals received at IPA VS during 1978 were forwarded to AID whereas the majority of new proposals were still being processed by IPA VS at the end of 1978.

Section 2: Sub-Grant Awards in 1978

1978 sub-grants, like those in prior years, were awarded to government agencies, non-profit medical and health institutions, professional and voluntary service organizations, and church groups. Sub-grant activity focused on the following areas:

Development of voluntary sterilization programs

Training of physicians in voluntary sterilization techniques

Training of health support staff to assist the physician, to counsel patients, and to maintain and repair voluntary sterilization equipment.

Voluntary sterilization educational programs for health professionals, government officials, and the community at large.

Development of voluntary sterilization educational materials and curricula

Development of indigenous leadership groups to promote voluntary sterilization

Provision of equipment and repair maintenance centers

Conference and seminars at national, regional, and local levels.

In addition to funding programs through regular sub-grants, IPAVS also supported projects via small grants and special equipment grants. Small grants were awarded for projects with a dollar value of under \$5,000 and processing time was usually less than that required by regular sub-grants. Special equipment grants were awarded for sub-grants requesting amounts of equipment but not other program components.

During 1978, IPA VS awarded 53 sub-grants in 22 countries for a total of \$2,920,000. In contrast to the trend set from 1972 to 1977, IPA VS sub-grant awards in 1978 showed their first decrease. There was a 26% decline in the number of sub-grants awarded (down from 73 in 1977) and a 24% decrease in total dollars committed (down from \$3,866,000). However, Lebanon was added as a country receiving sub-grant assistance for the first time.

A significant explanation of the decrease in sub-grant funds awarded during 1978 was the fact that much potential sub-grant activity was still in the proposal stage at the end of the year. As previously indicated in Table 2.2 a total of 61 proposals were in process at the end of 1978 which would involve an approximate commitment of \$7.25 million after AID approval is obtained.

Appendix A lists all sub-grants awarded in 1978 and provides basic budget and programmatic information on each one.

Table 2.4 shows the trends in IPA VS sub-grant awards over time, summarizing each calendar year since the inception of IPA VS in 1972. In 1978, 23 of the 53 sub-grants awarded (43%) were for new projects, whereas in 1977 this figure was 43 of 73, or 59%. The remaining 30 sub-grants awarded in 1978 (57%) were for continuation support of projects first funded in previous years.

There has been a general downward trend in new projects funded as a proportion of total projects awarded each year. This is because a larger proportion of support activity goes to projects that IPA VS is already committed to, and where IPA VS is working towards the eventual institutionalization of its programs.

Although the number of new projects awarded declined, there was an increase in IPA VS support of ongoing sub-grant activities in general. IPA VS provided program support to a total of 129 effective sub-grants in 1978 as opposed to 121 in 1977. The activities and accomplishments of sub-grants effective during the year are reported in subsequent sections.

Table 2.4 IPAVS Sub-Grant Funding Activities, 1972-1978

	1972-73	1974	1975	1976	1977	1978	TOTAL: 1972-78
A. NUMBER OF SUB-GRANTS AWARDED							
<u>New Sub-Grants</u>	(18)	(30)	(31)	(16)	(43)	(23)	(161)
AID Funded	18	25	25	13	39	22	142
Privately Funded	--	5	6	3	4	1	19
<u>Continuation Sub-Grants</u>	(4)	(5)	(8)	(26)	(30)	(30)	(103)
AID Funded	4	5	7	25	27	28	96
Privately Funded	--	--	1	1	3	2	7
TOTAL NUMBER	<u>22</u>	<u>35</u>	<u>39</u>	<u>42</u>	<u>73</u>	<u>53</u>	<u>264</u>
B. AMOUNT OF FUNDS AWARDED (in '000s)							
AID Funds	\$350	\$1,136	\$739	\$1,268	\$3,728	\$2,865	\$10,086
Private Funds	--	35	89	88	138	55	405
TOTAL AMOUNT	<u>\$350</u>	<u>\$1,171</u>	<u>\$828</u>	<u>\$1,356</u>	<u>\$3,866</u>	<u>\$2,920</u>	<u>\$10,491</u>

REGIONAL DISTRIBUTION OF SUB-GRANT AWARDS

The geographic distribution of IPAVS sub-grant awards has remained fairly constant each year since 1972 except for one noticeable shift in the South Asia region. This shift occurred in 1977 when the South Asia region was awarded a total of 22 sub-grants which tripled the number of any previous year. However, as noted in Table 2.5 the pattern of awards was resumed in 1978, when only 7 sub-grants were awarded to South Asia. It remains to be seen whether the anticipated establishment of IPAVS's Asia Regional Office in Bangladesh in 1979 will result in a greatly increased number of proposals from this region.

Table 2.5 Total Number and Percent of Sub-Grants Awarded by Region, 1972-1978

REGION	1972-73	1974	1975	1976	1977	1978	TOTAL 1972-78
East Asia	12 (54.5)	11 (31.4)	20 (51.3)	17 (40.5)	19 (26.0)	18 (34.0)	97 (36.7)
Central America	--	7 (20.0)	3 (7.7)	10 (23.8)	16 (21.9)	11 (20.8)	47 (17.8)
South Asia	--	5 (14.3)	4 (10.3)	8 (19.0)	22 (30.1)	7 (13.2)	46 (17.4)
Africa	1 (4.5)	--	5 (12.8)	1 (2.4)	4 (5.5)	7 (13.2)	18 (6.8)
South America	4 (18.2)	6 (17.1)	6 (15.4)	3 (7.1)	6 (8.2)	4 (7.5)	29 (11.0)
Middle East	1 (4.5)	2 (5.7)	--	2 (4.8)	2 (2.7)	4 (7.5)	11 (4.2)
Caribbean	4 (18.2)	3 (8.6)	1 (2.6)	1 (2.4)	3 (4.1)	2 (3.8)	14 (5.3)
Europe	--	1 (2.9)	--	--	1 (1.4)	--	2 (0.8)
TOTAL	22 (100.0)	35 (100.0)	39 (100.0)	42 (100.0)	73 (100.0)	53 (100.0)	264 (100.0)

Other noteworthy changes in the pattern of awards were the increases in sub-grant awards in the Middle East region (from 2 to 4) and in the Africa region (from 4 to 7). Both of these regions have had few sub-grants and IPAVS began to concentrate greater efforts there in 1978. In the other regions, the distribution of sub-grant awards has remained largely unchanged, on a percentage basis.

Countries receiving the most sub-grant awards in 1978 were Korea (7), Bangladesh (6), Egypt (5), the Philippines, and Thailand (4 each). A total of 22 countries received sub-grant awards in 1978 but IPAVS was involved in ongoing support of projects in 29 countries during the year. As mentioned, Lebanon was the only country to receive IPAVS sub-grant assistance for the first time. Pakistan, the leading recipient of sub-grant awards in 1977, almost dropped out of the picture completely in 1978 because of political considerations. The presence of Egypt on the 1978 list of leading recipients was a notable change from previous years. The increased commitment to Egypt demonstrated IPAVS's efforts in 1978 to "break ground" in Africa, a region with significant unmet voluntary sterilization needs.

REGIONAL DISTRIBUTION OF SUB-GRANT FUNDS

As in 1977, the three regions which accounted for the largest IPAVS sub-grant dollar awards in 1978 were Central America (42.2%), East Asia (25.8%) and South Asia (14.3%). However, the rank among these three regions changed when the dollar amount awarded in South Asia became higher than that awarded in East Asia. Table 2.6 shows the regional distribution of funds awarded in 1978. (See following page.)

As in 1977, Central America once again received the largest total dollar amount even though it did not receive the highest number of sub-grants awarded. In 1978, East Asia was awarded a total of \$753,000 for 18 sub-grants and Central America received a total of \$1,231,000

Table 2.6 Amount (in '000s) and Percent of Sub-Grant Funds Awarded by Region, 1972-1978

REGION	1972-73	1974	1975	1976	1977	1978	TOTAL 1972-78
Central America	54 (15.1)	107 (9.1)	76 (9.2)	396 (29.2)	1,507 (39.0)	1,231 (42.2)	3,371 (32.1)
East Asia	228 (63.7)	483 (41.2)	452 (54.5)	475 (35.1)	749 (19.4)	753 (25.8)	3,140 (29.9)
South Asia	8 (2.2)	203 (17.3)	97 (11.7)	407 (30.0)	937 (24.2)	418 (14.3)	2,070 (19.7)
Africa	16 (4.5)	--	114 (13.8)	7 (0.5)	429 (11.1)	244 (8.4)	810 (7.7)
Middle East	8 (2.2)	30 (2.6)	--	19 (1.4)	23 (0.6)	123 (4.2)	203 (1.9)
Caribbean	--	47 (4.0)	15 (1.8)	8 (0.6)	111 (2.9)	85 (2.9)	266 (2.5)
South America	44 (12.3)	300 (25.6)	75 (9.0)	43 (3.2)	89 (2.3)	66 (2.3)	617 (5.9)
Europe	--	1 (0.09)	--	--	21 (0.5)	--	22 (0.2)
TOTAL \$	358	1,171	829	1,355	3,866	2,920	10,499
TOTAL %	(100.0)	(100.0)	(100.0)	(100.0)	(100.0)	(100.0)	(100.0)

Table 2.7 Mean Budget Award of Sub-Grants by Region, 1978

REGION	Number of Sub-Grants	Mean \$ Amount
Central America	11	\$111,909
South Asia	7	59,714
Caribbean	2	42,500
East Asia	18	41,833
Africa	7	34,857
Middle East	4	30,750
South America	4	16,500

for 11 sub-grants. Table 2.7 shows the mean dollar amount per sub-grant in each region.

As can be seen, the Central America Region had by far the highest mean sub-grant award -- \$111,909 -- almost double that of the second highest region, South Asia. The relatively large dollar awards in Central America can be attributed to enormous equipment and renovation support given to Guatemala and Mexico, as well as to the fact that programs in this region tend to be in their first and second years when outlays are usually greater.

SOURCES OF SUB-GRANT FUNDING

A higher proportion of sub-grant funds committed by IPA VS in 1978, in comparison to previous year, were funds received from AID. A total of \$2,865,000 out of the \$2,920,000 committed, or 98% of all sub-grant awards, were from AID funds. The remaining \$55,000 of 2% were funds from private contributions raised by the Executive Committee of AVS for the purpose of supporting projects in countries ineligible to receive AID funds. Table 2.4 (page 2.9), also gives a breakdown of IPA VS sub-grant funds committed by year of award and source of funding. Three countries -- Brazil, Chile and the Republic of China -- received private funds during 1978. In addition to the three private-dollar

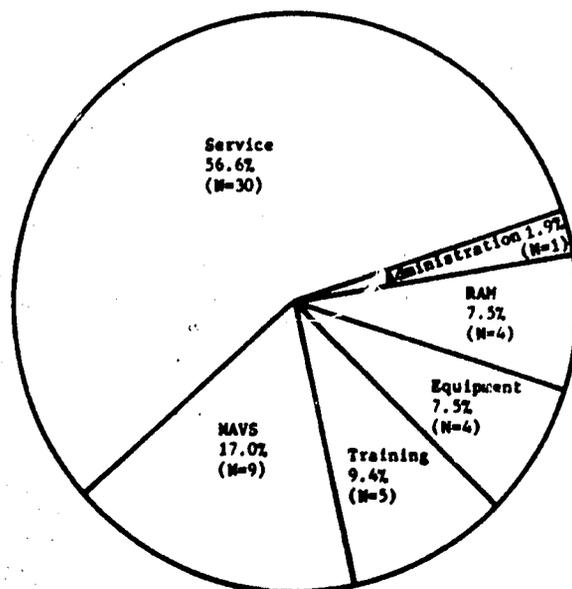
awards made in 1978, IPAVS supported the ongoing activities of six previously-awarded, privately-funded sub-grants during 1978. Awards from private contributions were more limited in 1978 because more countries were eligible to receive AID funds. As a result, private dollars awarded in 1978 showed a significant decrease (60%) from the previous year (down to \$55,000 from \$138,000).

PRIMARY EMPHASIS OF SUB-GRANT ACTIVITIES AND BUDGETS

IPAVS sub-grant activities concentrate on the areas of service, training, provision of medical equipment, information and education programs, and development and support of national associations for voluntary sterilization. For purposes of analysis, each sub-grant is classified according to the primary focus of its activities, although it may, and usually does, contain several types of program components.

Figure 2.3 below show the relative focus of each IPAVS program area according to the percent of sub-grants awarded in that area during 1978. The two sub-categories of repair and maintenance and administration were added in 1978. As expected, service sub-grants are of prime importance, representing 56.6% of total 1978 awards. National association sub-grants (17.0%) show an increase of 41.7% over 1977.

Figure 2.3 Distribution of Number of Sub-Grants by Primary Program Emphasis, 1978



The primary emphasis of one sub-grant was to administer two service grants and a training grant. There were no awards made in 1978 to sub-grants with I&E as the major emphasis. However, it is important to note that the majority of 1978 sub-grants (32) contained I&E program components, indicating that sub-grantees are becoming more aware of the need for integral I&E programs. Table 2.8 shows the frequency with which all program components occurred and demonstrates most clearly IPAVS' efforts in supporting well-rounded programs.

Table 2.8 Program Components by Frequency of Occurrence, 1978

<u>Component</u>	<u>Frequency</u>	<u>Number of Sub-grants</u>
Service	60.4%	32
I&E	60.4%	32
Equipment	45.3%	24
NAVS*	39.6%	21
Training	32.1%	17
Administration	11.3%	6
RAM	7.5%	4
Special Study	5.7%	3

*Includes grants which are administered by national associations

Table 2.9, which shows distribution of awards by budget category from 1972 to 1978, indicates clearly that a large proportion of awards has always been made in the Personnel and Medical Equipment categories. Other categories showing fluctuations from year to year are influenced by large single sub-grants, e.g., the categories of Training and I&E.

Table 2.9 : Distribution of IPAVS Sub-Grant Funds by Sub-Grant Budget Categories, 1972-1978

SUB-GRANT BUDGET CATEGORY	1972-73	1974	1975	1976	1977	1978	TOTAL AWARDS 1972-1978
Personnel	\$136,640*	\$424,745*	\$224,750	\$522,068	\$824,416	\$982,067	\$3,114,686
Service	*	*	137,901	230,368	405,131	372,239	1,145,639
Training	28,460	70,411	56,139	50,396	321,786	69,872	597,064
Information & Education	15,105	122,667	57,465	110,544	157,373	109,982	573,136
Medical Equipment	116,845	468,105	246,334	207,805	1,522,154	813,588	3,374,831
Renovation	--	--	--	--	**	80,446	80,446
Other	53,350	84,561	105,403	234,585	634,626**	492,064	1,604,589
TOTAL	\$350,400	\$1,170,489	\$827,992	\$1,355,766	\$3,865,486	\$2,920,258	\$10,490,391

* Service costs included with Personnel category for 1972-1974

** Renovation costs included with Other category for 1977

SMALL GRANT AWARDS

Since 1974, IPAVS has been awarding funds in the "small grants" category. These small awards were designed to avoid the long delays characteristic of the proposal review and approval process. The vast majority of small grants awards to date have been in the following areas:

1. Provision of individual items of medical and surgical equipment;
2. Travel and/or per-diem for selected conference participants or for key administrators and selected paraprofessionals for orientation to the work of IPAVS or IPAVS sub-grantees;
3. Training for physicians and paraprofessionals in administration and delivery of voluntary sterilization services, including training by specialists in surgical techniques and technical assistance provided by consultants;
4. Training of selected administrators and specialized technicians in the repair and maintenance of endoscopic equipment; and
5. Provision of audio-visual materials and equipment for use in information and education programs.

Table 2.10 shows Small Grant activities since 1974. (See the following page.)

In 1978, IPAVS awarded a total of 92 small grants, an increase of about 46% over 1977. Overall, in the five years since IPAVS started awarding small grants, a total of 249 awards have been made.

Most small grant awards each year were for medical and surgical equipment. Requests for medical equipment continued to grow in 1978 and were stimulated when IPAVS began for the first time to approve small grant awards for endoscopic equipment. Almost two-thirds (63.5%)

**Table 2.10: Number of Small Grants Awarded by IPAVS,
by Purpose, 1974-1978**

PURPOSE	1974	1975	1976	1977	1978	TOTAL 1974-1978
Medical Equipment	24	15	15	38	66	158 (63.8%)
Travel	1	4	10	3	8	26 (10.4%)
Training	6	7	11	6	10	40 (16.1%)
Audio-Visual Material	-	-	-	15	8	23 (9.2%)
Other	-	-	1	1	-	2 (0.8%)
TOTAL	31	26	37	63	92	249 (100.0%)

of all small grant awards in 1978 were for equipment.

From 1974 to 1978, IPAVS awarded small grants in all regions of the developing world. Appendix B lists small grant awards for 1978.

In 1978, Central America and Africa together received about two-thirds of all small grants awarded -- an indication of IPAVS's commitment to reinforce voluntary sterilization efforts in those regions.

SPECIAL EQUIPMENT GRANTS

Special equipment grants were established to provide equipment in bulk where there are no other direct IPAVS program costs involved. Three such grants were awarded this year:

1. One provided 250 mini-laparotomy kits and 250 vasectomy kits to the Bangladesh Association for Voluntary Sterilization (BAVS) to distribute to:

- a) already-established clinics set up by branches of the BAVS,
 - b) BAVS branches without established clinics, and
 - c) physicians trained at the BAVS Dacca clinic.
2. The second provided eight System "C"s to the Costa Rican Social Security System. A System "C" converts an existing electro-surgical system to falope-ring capability.
 3. The third provided 50 mini-laparotomy kits and 50 vasectomy kits to the Honduran Family Planning Association to distribute to designated government hospitals.

Chapter 3

PROGRAM ACCOMPLISHMENTS

Section 1: Service Acceptors

NUMBER OF ACCEPTORS

Service activities expanded greatly during 1978. An estimated total of 61,855 voluntary sterilization procedures were performed -- an increase of almost 30% since 1977. Male procedures formed approximately 20% of the total -- slightly higher proportion than in 1977.

Table 3.1 illustrates the regional variations in the number of procedures performed by IPAVS between 1972 and 1978. As can be seen, the number of male procedures performed increased substantially in Central America and South Asia. In fact, these two regions accounted for 80% of total male services delivered during 1978. There was a tremendous increase also in female services in Central America and South Asia. The number of female procedures performed in these regions between 1977 and 1978 increased by 84%.

In Africa the growing impact of IPAVS activities is demonstrated by the fact that three times as many voluntary sterilization procedures were performed in 1978 than in all the previous years of IPAVS involvement in the region. Nevertheless, the figure is still insignificant in view of the need (see Chapter I, Regional Reports).

The number of male and female acceptors in East Asia declined this year, primarily as a result of the fact that previously-funded sub-grants in

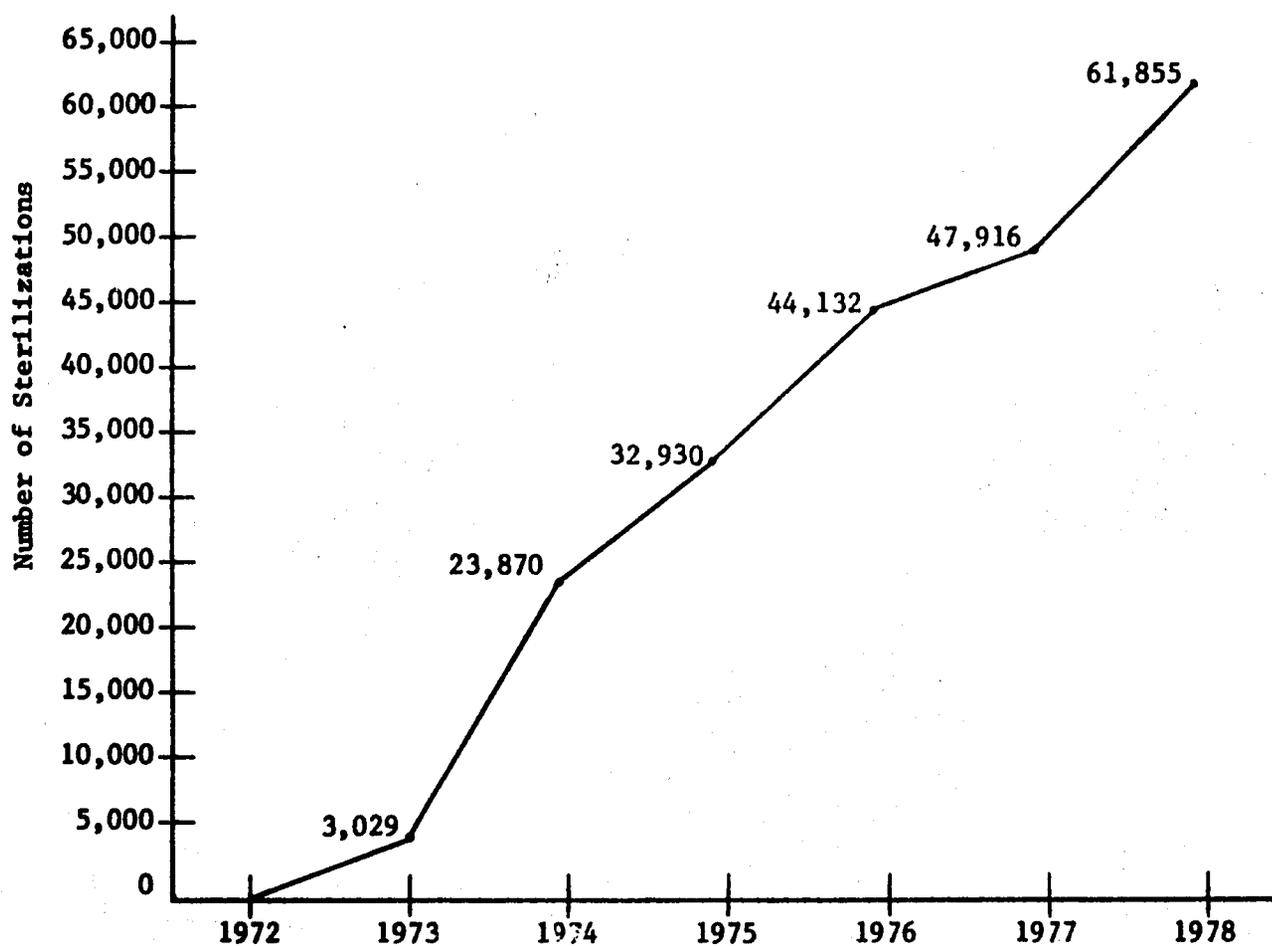
Table 3.1 : Number of Male and Female Sterilizations Reported Performed by IPAVS Sub-Grantees, by Region and Year

REGION	MALE STERILIZATIONS					FEMALE STERILIZATIONS					TOTAL
	1972-74	1975	1976	1977	1978*	1972-74	1975	1976	1977	1978*	
East Asia	1,088	1,868	2,226	1,394	1,279	14,664	17,535	20,706	17,089	9,166	87,015
South Asia	30	3,589	4,385	5,795	7,701	510	3,424	8,553	10,721	17,206	61,914
Middle East	--	--	--	--	116	134	210	20	335	817	1,632
Africa	--	--	--	--	--	--	172	269	61	1,454	1,956
Caribbean	24	24	8	--	6	575	1,433	554	701	1,487	4,812
Central America	--	70	437	1,528	2,723	5,571	3,765	3,998	8,184	17,633	43,909
South America	921	--	29	31	50	3,382	840	2,947	2,077	2,217	12,494
TOTAL	2,063	5,551	7,085	8,748	11,875	24,836	27,379	37,047	39,168	49,980	213,732

*Estimated

the Philippines now function as independent service centers, not counted in IPA VS Reporting. The steady expansion in the provision of voluntary sterilization services over time is demonstrated by Figure 3.1. To date, almost 214,000 voluntary sterilization procedures have been performed by IPA VS sub-grantees since 1972.

Figure 3.1 Number of Voluntary Sterilizations Performed by IPA VS Sub-Grantees, 1972-1978



The increasing number of acceptors in IPAVS sub-grants is completely consistent with recent survey data, such as the World Fertility Survey, which documents a large volume of unmet sterilization need. These surveys show that a surprisingly high proportion of couples with only two or three children want to cease childbearing. It is for these couples, as well as those with higher parities that IPAVS is working to expand the availability of surgical contraception services. For the foreseeable future, IPAVS has much work to do in its quest to satisfy the demand for surgical contraception.

In 1978, 32 grants with service components were awarded. As in previous years, IPAVS worked very closely with all service sub-grants to ensure effective, efficient and sensitive service delivery. IPAVS places great emphasis on service centers not only maintaining the highest medical standards but also treating patients in a pleasant and dignified manner.

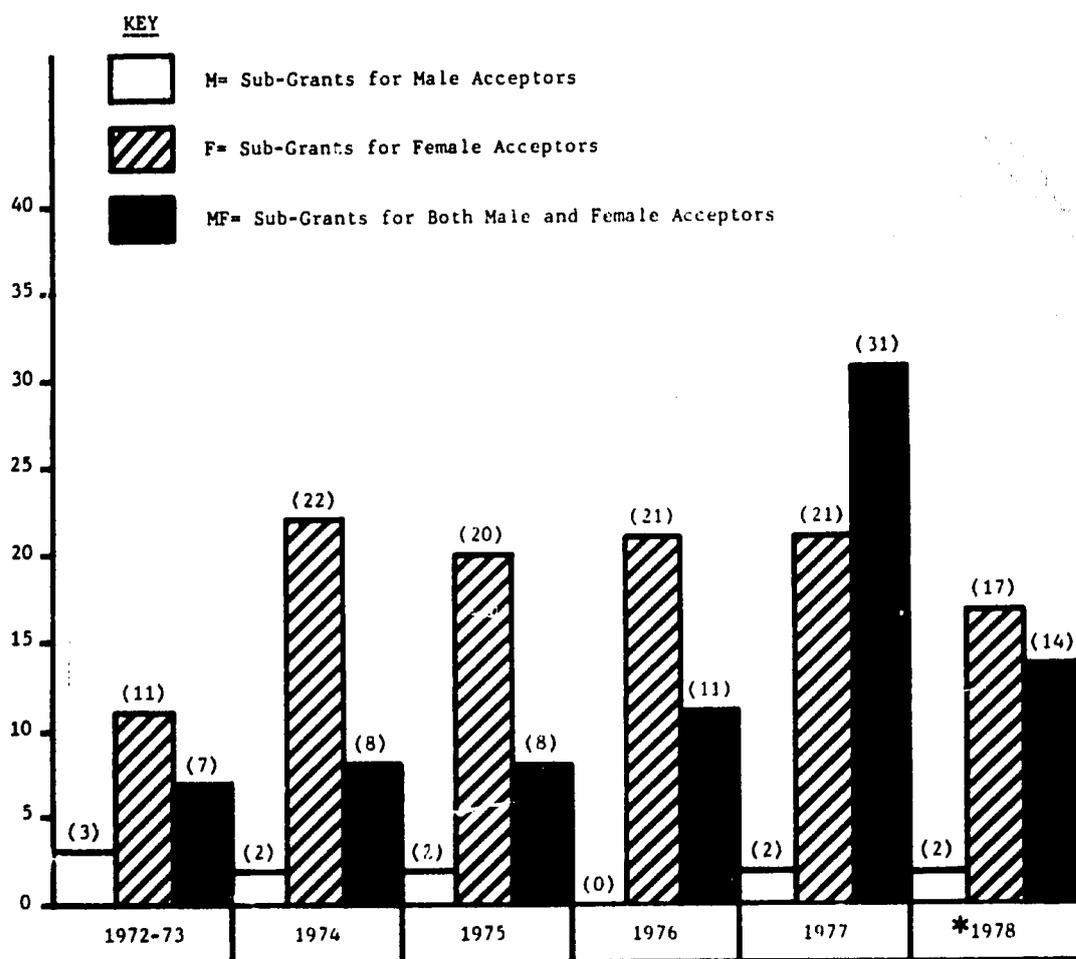
Innovative service delivery was initiated in 1978, e.g., mobile outreach teams working in underserved rural areas. IPAVS continued to fund clinic space in existing health care facilities for the exclusive provision of voluntary sterilization services. It is imaginative and resourceful service delivery, which also allows patients to feel well-treated both medically and socially, that is critical to the acceptance of surgical contraception.

ACCEPTOR GROUPS OF SERVICE PROGRAMS

As in the past, more service acceptors were women. Of the 35 sub-grants with service programs, 17 (48%) provided female sterilization services only, 14 (40%) provided both male and female sterilization services, and 2 (5.7%) provided male sterilization services only. The remaining two service sub-grants (5.7%) were unique among all sub-

grants ever funded by IPAUS. Both programs were administered by the Korean AVS: one offered treatment of complications from sterilization operations (operations not necessarily funded by IPAUS) and one provided vasovasotomies in specially selected cases. Figure 3.2 depicts the relative importance of each target group for each calendar year since 1972.

Figure 3.2 Number of IPAUS Sub-Grants, 1972-1978, with Service Program Components Awarded, by Type of Target Population



*Does not include two programs for treatment of complications and for vasovasotomy

While awards for each of the single-gender service programs in 1978 remained at a near constant level, awards for programs offering both male and female sterilization services seemed to be equalling or surpassing the level equivalent to that of the female programs. IPAVS predicts that this trend towards dual services will continue in the future.

A look into the geographic distribution of these awards showed that in 1978, Africa (3), the Caribbean, (1), the Middle East (2), and South America (4) were awarded sub-grants for female sterilization services only. Male only service programs were funded in Central America (1) and East Asia (1). The South Asia region (4) was awarded combination programs only, whereas Central America and East Asia, the only regions to receive funds for male only programs, were awarded sub-grants with male only, female only and dual target populations. These two regions (Central America and East Asia) also received the highest numbers of sub-grants awarded in 1978.

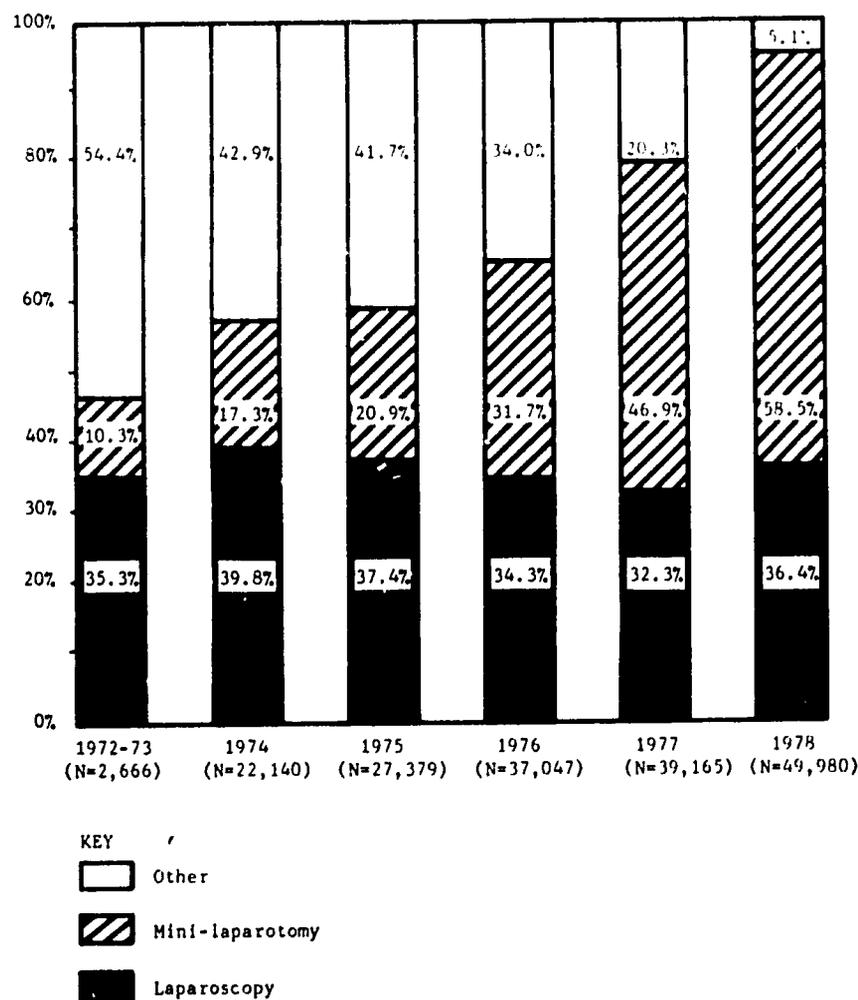
CHOICE OF SURGICAL PROCEDURE

The selection of a female sterilization procedure depends on a number of factors, such as the physician's surgical training; availability of facilities, equipment, and support personnel; health of the patient; the administrative and logistical support organization; equipment maintenance and repair capability; and cultural factors. These are just some of the variable that determine the choice of procedure. Wherever possible, IPAVS encourages the use of simplified voluntary sterilization techniques that can be performed on an out-patient basis. Since vasectomy and mini-laparotomy both fulfill these requirements, IPAVS has actively promoted them as the best-suited for large-scale delivery in both urban and rural areas. IPAVS is gratified to note that two-thirds of all procedures performed in service sub-grants during 1978

were either mini-laparotomies or vasectomies.

Mini-lap in particular has proven to be highly acceptable to the professional medical community around the world. In just one year, the proportion of mini-laparotomies increased from 47% to 59% of all female procedures. Its increasing importance continues a trend already apparent in service sub-grants for several years. This trend is illustrated by Figure 3.3 which illustrates the popularity of various female methods over time.

Figure 3.3 Method-Spectrum Shift for Female Sterilizations Reported by IPAVS Sub-Grantees, 1972-1978



As mentioned, cultural factors also influence the selection of a female procedure. This phenomenon is illustrated by the regional variation in popularity of the methods. For example, during 1978, laparoscopy was the method of choice in Central America, Africa and the Middle East, whereas mini-lap was the most popular method in Asia, South America and the Caribbean. These regional differences are illustrated in Table 3.3. Vaginal methods of sterilization were most prevalent in Africa and the Middle East region, but overall they accounted for less than 2% of all female procedures performed. The lack of popularity of these vaginal methods may be due to their technical difficulty, and their unpopularity among acceptors.

Table 3.3 also compares the incidence of vasectomy procedures in IPAVS service sub-grants. Vasectomies are particularly popular in South Asia where they comprise almost one-third of all sterilization procedures performed. Credit for the prevalence of vasectomies in South Asia should be given to our sub-grantees in the region who have persisted in providing the service in a highly innovative manner. On the other end of the spectrum, virtually no vasectomies were performed by sub-grantees in Africa and the Caribbean. IPAVS actively encourages all sub-grantees to expand their male sterilization services, but to do so recognizing the myriad cultural, educational and attitudinal problems that need to be overcome before males accept vasectomy.

DEMOGRAPHIC IMPLICATIONS

Although sterilization is the most effective of all family planning methods, its impact on population growth rates depends as much on age and parity of acceptors as it does on acceptance and use. In 1978, IPAVS undertook a comprehensive review of the demographic characteristics of acceptors to see if there were any significant trends developing.

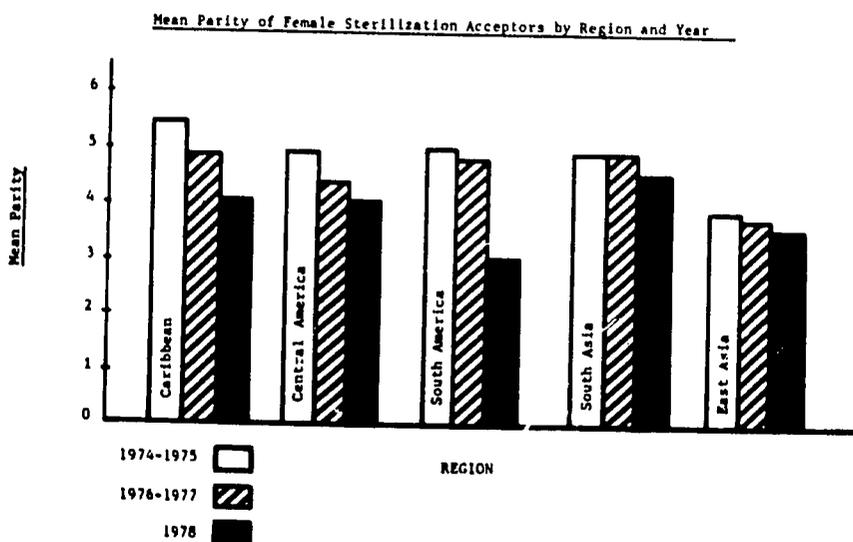
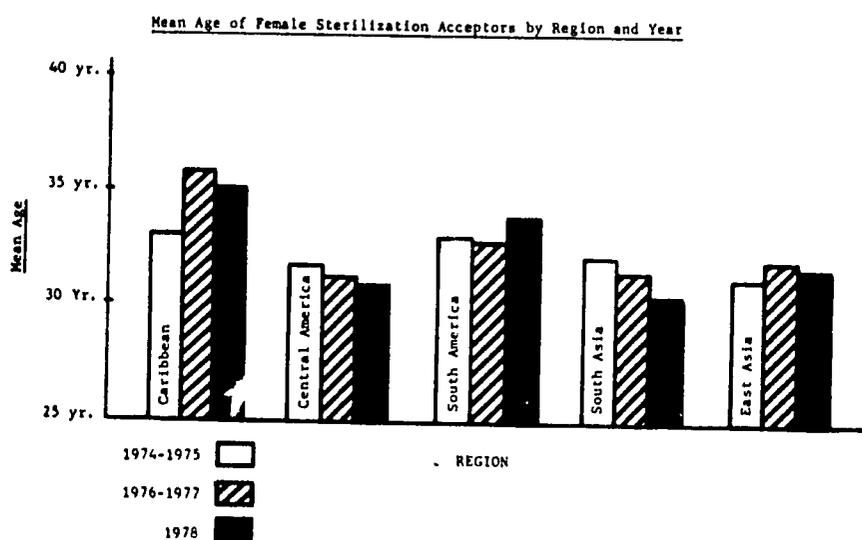
Table 3.2: Estimated Number of Sterilizations Performed by IPAVS Sub-Grantees, 1990-1991, by Procedure and Region

PROCEDURE TYPE	East Asia	South Asia	Central America	South America	Africa	Middle East	Caribbean	TOTAL PROCEDURES
Laparoscopy	2,846 (31%)	2,133 (12.2%)	11,136 (63.2%)	726 (32.7%)	766 (53%)	349 (42.7%)	256 (17.2%)	18,212 (36.4%)
Mini-lap	5,974 (65.2%)	14,743 (86%)	5,678 (32.2%)	1,441 (65.1%)	408 (28%)	167 (20.5%)	862 (58%)	29,273 (58.5%)
Coloptomy	38 (.4%)	154 (.8%)	0	23 (1%)	0	9 (1.1%)	0	224 (.5%)
Culdoscopy	0	0	272 (1.5%)	0	220 (15%)	117 (14.3%)	0	609 (1.2%)
Other*	308 (3.4%)	176 (1%)	547 (3.1%)	27 (1.2%)	60 (4%)	175 (21.4%)	369 (24.8%)	1,662 (3.4%)
TOTAL FEMALE	9,166 (100%)	17,206 (100%)	17,633 (100%)	2,217 (100%)	1,454 (100%)	817 (100%)	1,487 (100%)	49,980 (100%)
								GRAND TOTAL FEMALE
TOTAL VASECTOMY	1,279	7,701	2,723	50	0	116	6	11,875
Percentage of all procedures	(12.2%)	(31%)	(13.4%)	(6.6%)		(12.4%)	(.4%)	(19%)
								GRAND TOTAL MALE
TOTAL BY REGION	<u>10,445</u>	<u>24,907</u>	<u>20,356</u>	<u>2,267</u>	<u>1,454</u>	<u>933</u>	<u>1,493</u>	<u>61,855</u>
								GRAND TOTAL

*Includes all traditional interval laparotomy procedures and all other procedures where type is unknown.

Figure 3.4 shows the regional distribution in the mean age and mean parity of female acceptors from IPA VS sub-grants over time. As can be seen, female acceptors fell between the ages of 30-35, with the highest mean ages in the Caribbean area and the lowest in Asia. The 30-35 age group is usually the first to seek services when they become available since they are the highest parity group most anxious to end their childbearing years.

Figure 3.4 Regional Trends in Mean Age and Mean Parity of Female Acceptors of IPA VS Grants, 1974-1978



There was no downward trend in mean age for any region except South Asia, a region which is extremely important for IPAVS. Almost 62,000 female procedures have been performed by our sub-grantees and IPAVS is gratified to note the declining age of acceptors in South Asia. This is an indication of maturing programs that are now serving a younger clientele with fewer children. Facing longer years of reproductive life ahead, the younger group is seeking services before they become multiparous.

Of major importance is the consistent downward trend in parity -- obviously a function of younger age -- which is apparent in all IPAVS' regions. The most dramatic declines are occurring in South America in spite of the fact that the region is a primarily Catholic, supposedly pro-natalist, and "macho" culture. The downward trend is expected to become more pronounced each year.

IPAVS believes these developments reflect not only the innovative delivery systems used by sub-grantees, but also the expansion of their I & E efforts. It is hoped that service delivery can be further improved so that it will become available to all who seek it.

COSTS OF PROVIDING VOLUNTARY STERILIZATION SERVICES

During 1978, IPAVS performed a comprehensive analysis of the costs of providing voluntary sterilization services. Tables 3.3 and 3.4 show the weighted mean dollar cost of male and female procedures in the various regions. Costs included in these calculations were salaries of all sub-grant personnel involved in providing services, costs of operating the clinic facilities, reimbursements to the sub-grant institution, food for patients, surgical supplies and miscellaneous bookkeeping and bank charges. The total number of procedures provided by each grant was divided by the sum of the costs listed above in order to calculate the average cost per procedure.

Calculations were performed separately for male and female service projects.

Table 3.3: Regional Variations in Costs of Providing Female Procedures in IPA VS Sub-Grants, 1978

REGION	Weighted Mean \$ Cost	Number of Grants
East Asia	17.22	30
South Asia	14.79	15
Central America	27.21	19
South America	20.01	11
Caribbean	39.03	6
Middle East	40.41	6
Africa	33.78	4
TOTAL	20.20	91

As can be seen from the tables, costs of providing both male and female services are lowest in South Asia and highest in Africa, an area of recent but growing IPA VS activity. During 1978, the overall mean cost of providing female services in all regions was approximately

\$30 and for male procedures, the cost was approximately \$8.

Table 3.4: Regional Variations in Costs of Providing Male Procedures in IPAUS Sub-Grants, 1978

REGION	Weighted Mean \$ Cost	Number of Grants
East Asia	9.08	10
South Asia	5.26	9
Central America	14.39	13
South America	14.08	2
Caribbean	11.89	3
TOTAL	6.96	37

Program costs increase inevitably as a result of the enormous rates of inflation experienced by many developing countries. However, IPAUS actively encourages sub-grantees to expand their service programs (and thus take advantage of economies of scale) and also to utilize efficient management techniques in the administration of their projects.

COMPLICATIONS

IPAUS maintains and enforces strict medical standards regarding the provision of voluntary sterilization services. The maintenance of high-quality medical standards has become even more important as the demand for services has increased.

IPAVS does not perform clinical follow-up studies of the patients from our sub-grantees. However, sub-grantees are requested to report all major complications and failures to IPAVS. During 1978, the Complications Reporting Form was modified and expanded to allow a more effective monitoring of the quality of voluntary sterilization services provided by our sub-grantees. IPAVS is gratified to note that the incidence of deaths and major complications has declined every year.

In 1977, four deaths out of 39,168 female sterilization procedures i.e., 1021 deaths per 100,000, were recorded. This compares favorably with a mortality rate of 10.4 per 100,000 laparoscopic sterilization procedures in a survey recently conducted in the United Kingdom. In 1978, no deaths resulted from sterilization procedures reported by IPAVS service sub-grants. The lack of reported deaths could be a consequence of the increased experience acquired by sub-grantees over time; however the possibility of under-reporting must not be overlooked.

In 1977, a few uterine perforations and bladder injuries were reported. In 1978, 17 major complications were reported out of a total of 49,980 female procedures (.34 per 1,000 procedures). In one instance, there was a failure that resulted in an extrauterine pregnancy and rupture of the oviduct following laparoscopic cauterization. Tubectomy was performed on the ruptured tube. Other reported complications include cases of hemorrhage; wound infection; stitch infection; incomplete perforation of the uterus; tubal ring in the mesosalpinx; and tearing of the tube, mesosalpinx, and cervix. Proper treatment was administered and no permanent untoward effects have been reported.

Some risk is inevitable in any surgical procedure. It is the goal of IPAVS, largely achieved during 1978, to keep any risks associated with voluntary surgical contraception down to the very minimum.

Section 2: Training Activities

IPAVS has always worked to incorporate voluntary sterilization services within national health and family planning programs. Since a cadre of trained professionals is basic to the achievement of this goal, IPAVS actively supports training in surgical contraception techniques for everyone from physician to auxillary support team to equipment maintenance technicians. These training programs have ranged in scope from local to national levels.

The impressive gains made by IPAVS training sub-grantees during 1978 reflect IPAVS's commitment to training programs tailored to fit indigenous needs and demands.

PHYSICIAN TRAINING

In 1978, there were 129 ongoing sub-grants, 38 of which had a physician training component. Sixteen new training grants were awarded in 1978, five of which were in East Asia, four in Central America, three in South America, three in the Middle East and one in South Asia.

IPAVS encourages the funding of governmental training programs, since it is felt that government involvement is a step forward in the process of institutionalization of voluntary sterilization services. In 1978, funds for the following training programs, were awarded to the national government of the country involved.

Country and Institution

Tunisia

Mexico

Instituto Mexicano del Seguro Social

Objectives

To establish a national training center and train 400 physicians in mini-laparotomy and laparoscopy.

To conduct a training program to train 36 physicians in mini-laparotomy and laparoscopy.

Secretaría de Salud y
Asistencia

To train 27 physicians in mini-
laparotomy and laparoscopy.

An upward trend in the number of physicians trained in all sterilization procedures is evident in Table 3.5. IPAVS records showed an impressive cumulative total of 2,760 physicians trained by the end of 1978.

Table 3.5: Trends in IPAVS Physician Training, 1973-1978

	1973	1974	1975	1976	1977	1978	CUMULATIVE TOTAL
No. Trained in Male Procedures	26	37	78	173	207	227	748
No. Trained in Female Procedures	49	324	387	417	478	765	2,420
Ratio, Male to Female	1:1.9	1:8.8	1:5.0	1:2.4	1:2.3	1:3.4	1:3.2
Total No. of Individual Physicians Trained	60	290	375	493	549	993*	2,760

* Projected figure

Table 3.5 indicates that 26 physicians were trained in vasectomy in 1973, increasing to 227 trainees in 1978; the number of trainees for female procedures shows a more dramatic rise from 49 trainees in 1973 to 765 trainees in 1978. During 1978, 50% more physicians were trained in female procedures than in the previous year. The ratio of trainees in vasectomy to those trained in tubal ligation was 1:3 in 1978.

NUMBER OF PHYSICIANS TRAINED BY REGION

In 1978, 993 physicians were trained in male and female sterilization procedures in all regions. (Table 3.7). East Asia had the highest number of trainees (405) followed by 277 trainees from Africa and 166 from Central America. It should be noted that in 1977, only 549 physicians were trained in all sterilization procedures, with the maximum number of trainees from East Asia (203) and only one from Africa.

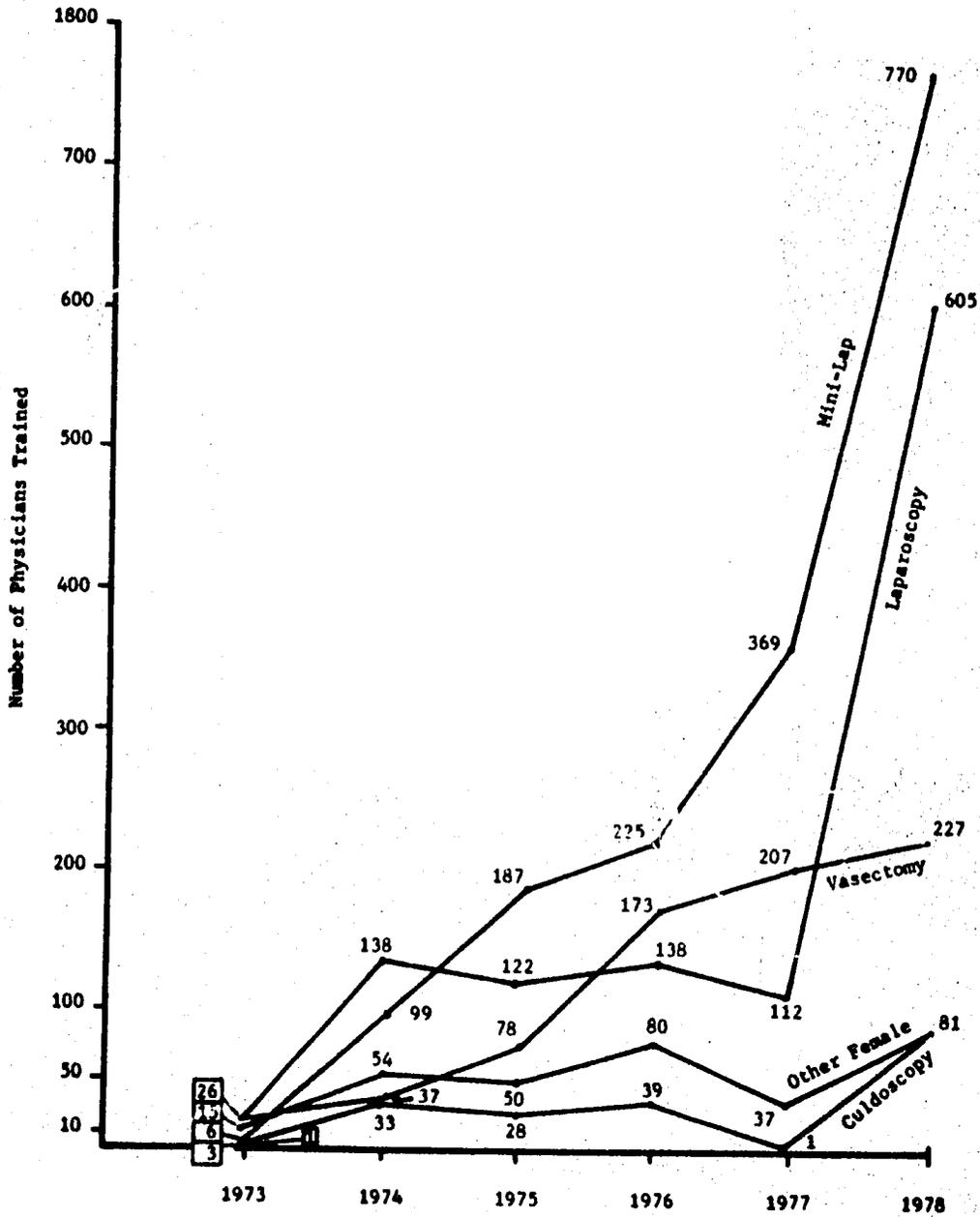
Table 3.6 Number of Physicians Trained in 1978, by Type of Procedure and Region

TYPE OF PROCEDURE	East Asia	South Asia	Africa	Central America	South America	Middle East	TOTAL
Laparoscopy	143	21	275	139	13	14	605
Laparotomy:							
Interval	1	-	-	-	1	-	2
Post-Partum	46	-	-	9	1	-	56
Mini-Laparotomy	270	91	275	103	19	12	770
Culdoscopy	67	-	2	-	-	12	81
Colpotomy	-	-	7	-	-	2	9
Other	14	-	-	-	-	-	14
Total Trained in Female Procedures	274	103	277	79	25	14	772
Total Trained in Vasectomy	142	59	0	26	0	0	227
Total Number of Physicians Trained *	405	103	277	166	28	14	993

*The numbers in the columns do not add up to the total number of physicians trained because some physicians are trained in more than one procedure.

Changes in the number of trainees in different sterilization procedures are demonstrated in Figure 3.5.

Figure 3.5: Number of Physicians Trained in Voluntary Sterilization Procedures, by Type of Procedure and Year



In 1977, there were three times as many trainees in mini-laparotomy (369) as in laparoscopy (112). In 1978, a sharp upward trend is revealed in the number of trainees in mini-laparotomy and laparoscopy over the previous year; mini-laparotomy still remains the most popular method taught in IPAVS training programs. Culdoscopy showed an increase from one trainee in 1977 to 81 in 1978.

It is not difficult to understand the popularity of mini-laparotomy. This procedure is relatively easy for physicians to learn, requires a shorter training period and simpler instruments than other female methods. Mini-laparotomy can also be performed either as a post-partum or interval technique, has a low complications rate, and requires only a small incision. Because of its many advantages, such as simplicity, low dependency on sophisticated equipment and support staff, mini-laparotomy is likely to remain the most popular female procedure in IPAVS training sub-grants. It is the most easily adaptable technique for the difficult and often imposing situations so frequently found in the developing world.

TRAINING FOR HEALTH SUPPORT PERSONNEL

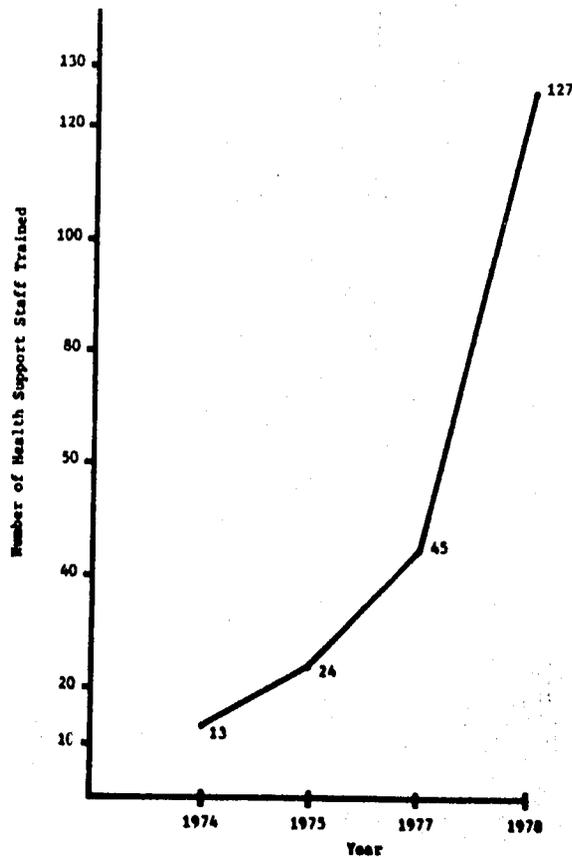
The increasing demand for surgical contraception and the concomitant proliferation of centers, camps and free-standing clinics have led to an urgent need for additional health personnel to assist the physician. IPAVS has responded to this shortage by encouraging the inclusion of health support staff in sub-grant training programs. There are many advantages to using the skills of health support staff to supplement those of the physician. The use of auxiliary health personnel is cost-effective since it is likely to increase the efficiency of service delivery and to improve quality of care by relieving the physician to perform other more specialized tasks.

The training programs funded by IPA.VS for health support staff are designed to train nurses, midwives, auxiliary nurses and social workers in the following areas:

1. Assisting physicians in performing voluntary sterilization procedures.
2. Helping maintain sterilization equipment.
3. Promoting health education in the area of sterilization.
4. Helping the management of patients in the pre-operative and post-operative stages of treatment.
5. Assisting in patient counseling.

IPA.VS involvement in training health support personnel is clearly reflected by a steady rise in the number of trainees from 13 in 1974 to 127 in 1978, as illustrated by Figure 3.6.

Figure 3.6 Number of Health Support Staff Trained from 1974-1978



During 1978, there were 11 sub-grants with a training component for health support staff; this compares with 8 such sub-grants during 1976 and 1977. A list of sub-grants with health support staff training components is given in Table 3.7.

Table 3.7: IPAVS Sub-Grants with Health Support Personnel Training Objectives, 1978

Sub-Grant	Objectives
<u>BANGLADESH</u>	
062-049-3S 062-049-4S	Train 70 Persons as allied health personnel for voluntary sterilization services; train 25 social workers.
<u>BRAZIL</u>	
094-070-P3	Train 5 nurses as physicians' assistants and in laparoscopic equipment maintenance.
<u>EL SALVADOR</u>	
147-091-2	Train 10 nurses as physicians' assistants and in laparoscopic equipment maintenance.
<u>CHILE</u>	
055-082-2 055-082-3	Train 13 midwives and nurses to assist in Family Planning Clinics and voluntary sterilization service delivery.
<u>GUATEMALA</u>	
156-109-2	Train 12 nurses as assistants in mini-laparotomy and laparoscopy procedures.
<u>TUNISIA</u>	
096-122-1	Train 30 midwives and 40 nurses as physicians' assistants and in laparoscopic equipment maintenance.
TOTAL <u>205</u>	

In 1977, nearly all formal auxiliary training was in Latin America. However, during 1978, Bangladesh and Tunisia led other sub-grantees in the number of health support trainees included in their programs. Also in 1978, IPAVS sponsored a very innovative program initiated by BAVS in Dacca. A course was designed to train individuals without any formal background in health as health support personnel. The only prerequisite was interest, vocational aptitude and a high school education. Candidates for the program were trained in patient counseling, assisting in operating procedures, and sterilization and maintenance of surgical equipment. The purpose of this training program was to compensate for the shortage of nurses and auxiliary health personnel and to increase work output of professional staff. An estimated 48 support staff have been trained in this program so far. IPAVS encourages indigenous initiative to develop training programs tailored to the particular needs and goals of the country concerned. IPAVS also expects that there will be a growing use of health support staff to supplement the work of the physician in meeting the ever-growing demand for voluntary sterilization services.

TRAINING EVALUATION

A growing organizational concern is the evaluation of training programs and the follow-up of trainees. The IPAVS field clinician is currently developing procedures for this and is expected to complete them during 1979. One evaluation that occurred during 1978 was the assessment of the training program at the Ramathibodi Hospital (Thailand).

1. The effectiveness of decentralized, generational training in female sterilization in Thailand.
2. The extent of institutionalization of voluntary sterilization in the trainees' respective institutions, and in the Thai national health care systems.

A final report of this study will be completed during 1979.

The steady increase in the number of trainees has led to continuous monitoring and evaluation to ensure adequate training of those physicians certified under IPAUS-sponsored programs.

Section 3: Equipment Support Activities

For many IPAUS training and service sub-grants, implementation of programs depends on the availability of medical and surgical equipment. During 1978, 56% of all IPAUS sub-grants had equipment components ranging from approximately \$280 to \$306,000.

EQUIPMENT DISTRIBUTION

Equipment distribution activities continued to increase, with 1,250 pieces of major medical and surgical equipment provided this year as against 1,098 items provided during 1977.

Table 3.8 Number of Major Equipment Items Ordered for IPAUS Projects

EQUIPMENT ITEM	1978	1977	% Difference 1978-1977
Laparoscopes, System "A"	41	80	-49%
System "C"	8	10	-20%
Teaching Attachment	9	11	-18%
Scopes only	16	9	+77%
Vasectomy Kits	380	208	+83%
Colpotomy Kits	2	12	-83%
Mini-laparotomy Kits	614	523	+17%
Culdoscopy Kits	33	10	+230%
Falope-Ring Applicators	6	139	-96%
Forceps	59	31	+90%
Anesthesia Machines	17	9	+89%
O/R Tables	5	10	-50%
O/R Lights	31	18	+72%
Gomco Aspirators	22	15	+47%
Autoclaves	7	13	-46%
TOTAL	1,250	1,098	+13.8%

Although the number of equipment items increased from 1977 to 1978, the dollar amount expended decreased (\$700,000 in 1977 vs. \$550,000 in 1978). This dollar decrease can be explained by the fact that the 1977 figures included an abnormally large commitment to the Government of Mexico for 55 complete laparoscopes, 90 mini-laparotomy kits, 50 falope-ring applicators, as well as other items for a total of \$295,200.

The figures in Table 3.8 show a continued high demand for mini-laparotomy kits. The increase in demand for these kits is partly explained by the fact that IPAVS began supplying several African countries for the first time in 1978. During 1979, IPAVS expects to increase the supply of equipment to the Africa region.

Vasectomy kits continued to be requested and supplied in large quantities to those regions that do not have cultural or other biases against male sterilization.

Table 3.9 compares the volume of equipment items distributed in 1977 with 1978, (page 3-25)

Several factors are apparent from an examination of the table. The large increase in minilap and vasectomy kits supplied to East and South Asia represents IPAVS' continued support of simplified surgical techniques. Particularly large quantities of vasectomy kits were supplied to Bangladesh (South Asia) and to Korea (East Asia) where a four-site vasectomy training grant was awarded to the Korean Association for Voluntary Sterilization. The decrease in the number of equipment items supplied to Central America (211 in 1978 vs. 531 in 1977) was the result of the above-mentioned Government of Mexico grant that inflated the 1977 figures. The large increase in the number of laparoscopes and culdoscopy kits supplied to East Asia (27 vs. 3 and 29 vs. 7) was the result of new sub-grant activity in Indonesia.

**Table 3.9 Regional Distribution of Equipment Ordered by IPAVS,
by Type of Equipment, 1978 (1977 figures in parentheses).**

EQUIPMENT ITEM	EAST ASIA	SOUTH ASIA	MIDDLE EAST	AFRICA	CARIB-BEAN	CENTRAL AMERICA	SOUTH AMERICA	OCEANIA	TOTAL
Laparoscopes	27(3)	2(1)	-	1(4)	2(0)	9(72)	-	-	41(80)
System "C"	-	-	-	-(8)	-	-(2)	8(0)	-	8(10)
Teaching Attachment	5(3)	-	-(1)	1(2)	-	3(5)	-	-	9(11)
Scopes only	8(2)	-(2)	1(0)	-(1)	-	7(4)	-	-	16(9)
Vasectomy Kits	121(14)	254(120)	4(2)	1(2)	-	-(68)	-(2)	-	380(208)
Colpotomy Kits	-(2)	-	-	-(8)	-	-	2(2)	-	2(12)
Mini-laparotomy Kits	110(115)	276(140)	6(1)	82(43)	4(7)	125(200)	5(12)	6(5)	614(523)
Culdoscopy Kits	29(7)	-	-	2(0)	2(3)	-	-	-	33(10)
Falope-Ring Applicators	1(4)	-(1)	-(1)	-(4)	-(1)	4(128)	-	1(0)	6(139)
Forceps	46(0)	-(7)	-(2)	1(20)	-	12(2)	-	-	59(31)
Anesthesia Machines	1(0)	2(1)	-	1(0)	-	13(8)	-	-	17(9)
O/R Tables	1(0)	-(2)	-	3(0)	-	1(8)	-	-	5(10)
O/R Lights	-	8(4)	-	4(0)	-	19(14)	-	-	31(18)
Gomco Aspirators	2(0)	1(5)	-	-	2(0)	17(10)	-	-	22(15)
Autoclaves	-	1(2)	-	3(0)	2(1)	1(10)	-	-	7(13)
TOTAL	351(150)	544(285)	11(7)	99(92)	12(12)	211(531)	15(16)	7(5)	1250(1098)

NEW INSTRUMENTATION

This year, negotiations were held between the General Services Administration, KLI, Inc., AID, and the donor agencies to finalize plans for the introduction of the laprocator during the year 1979.

The laprocator, developed by KLI, is a combined falope-ring applicator and laparoscope. The falope-ring method of tubal occlusion, found to be simpler and less dangerous than occlusion by electro-surgical means, has become the most commonly used method among our sub-grantees. The new laprocator is designed to reduce the cost of equipment in two ways:

1. The straight optics design requires fewer parts and is therefore cheaper to manufacture than the present system,
2. Fewer parts mean easier assembly and less expensive repair costs.

IPAVS has pledged to supply 250 laprocators over the next two years, a commitment of approximately \$500,000 .

REPAIR AND MAINTENANCE (RAM) CENTERS

Recognizing the fragile nature of surgical equipment and the need to have it repaired locally to save valuable program time, IPAVS has continued to fund new and existing RAM centers. During 1978, the following countries were sites of new RAM centers which became fully operational (figures in parenthesis represent total budget in dollars.)

- | | |
|--------------|-------------|
| 1. Indonesia | (\$36,590) |
| 2. Mexico | (\$145,016) |
| 3. Panama | (\$49,650) |

A new RAM Center in Honduras, recently approved by AID/Washington, will become operational during 1979.

In addition to the above, RAM Centers were funded in total or in part by IPAVS during 1978 in the following countries:

- | | |
|---|-------------|
| 1. Egypt | (\$42,546) |
| 2. El Salvador, a small grant for a technician's salary | |
| 3. Guatemala | (\$515,208) |
| 4. Korea | (\$36,686) |
| 5. Thailand | (\$51,550) |
| 6. Tunisia | (\$38,232) |

In order to assist these centers, IPAVS has completed a Repair and Maintenance Protocol to be used as a guide in planning, organizing and implementing an endoscopic repair centers. This protocol will become available in 1979 to all organizations contemplating such a center and to all existing RAM Centers.

Concurrently with the funding of RAM Centers, IPAVS has continued to fund the training of technicians at KLI's two-week factory training course. During 1978, there were four training sessions at KLI funded by IPAVS in which the following number of persons received training:

Honduras	2
Mexico	2
Indonesia	1
Taiwan	1
Gua emala	1
Tunisia	1

LOCAL PURCHASES

Our contract with AID stipulates that 20 sub-grants awarded between December 1, 1977 and November 31, 1978 may contain budget lines of over \$5,000 but less than \$15,000 in local purchases. This stipulation recognizes that in some cases, it may be less expensive and quicker for a sub-grantee to buy some equipment items locally rather than for IPAVS to do so. The following sub-grants fell into this category:

062-049-4S	Bangladesh	\$7,304
197-121-1	El Salvador	15,000

073-130-1	Egypt	9,022
245-140-1	Mexico	15,000
244-131-1	Mexico	9,000
217,049-1S(04)	Bangladesh	6,000

Chapter 4

INFORMATION AND EDUCATION ACTIVITIES

IPAVS has always placed high priority on Information and Education. A major organizational objective is the incorporation of grass roots I & E projects into the service, training, and national association programs of subgrants. In the past few years, sub-grantees have matured in their perceptions of the importance of I & E in their programs and have become more willing to allocate money for I & E components. Many sub-grantees have initiated highly innovative projects that have included radio, television, newspapers, posters, brochures, house-to-house educators, and libraries. I & E materials have also been designed specifically for the professional medical/health community. All of these activities reflect IPAVS's success in educating its sub-grantees about the vital role of I & E in all program efforts.

IPAVS also sponsors conferences, workshops, and seminars of various kinds so that participants can learn about the many aspects of voluntary surgical contraception as well as the latest innovations and technologies in the field. I & E activities supported by IPAVS are extremely varied and sub-grantees are encouraged to develop their own approaches to disseminating knowledge about their programs.

In addition to local I & E programs, IPAVS also supports large I & E programs that may be national or regional in scope, but in general, I & E components have consisted of local level programs that supplement service and training activities. NAVS sub-grants, on the other hand, have designed their educational projects for opinion leaders such as community and religious officials, teachers and the professional health community.

I & E ASSISTANCE TO SUB-GRANTS

Of the 129 sub-grants which were active during all or part of 1978, 59% had I & E components. The regional distribution of these I & E projects, along with their average dollar value is given below:

Table 4.1: Average \$ Amount of I&E Expenditures of Sub-Grants Effective During 1978, by Region

	<u>Africa & Middle East</u>	<u>East Asia</u>	<u>South Asia</u>	<u>Central America</u>	<u>South America</u>	<u>Caribbean</u>	<u>TOTAL</u>
Number of Grants with I&E Components	14	25	18	13	4	2	176
Average \$ Value of I&E Expenditures	1,598	2,715	2,143	4,583	721	773	Overall Average 2,537

¹Includes continuing sub-grants

As would be expected the bulk of I & E activities occurred in Asia, IPAVS' busiest region. In 1979, I & E activity will be expanded in Africa and the Middle East as part of a comprehensive effort to augment voluntary sterilization activities in that region. Of the 53 sub-grants awarded during 1978, 33 (62%) had I & E components. Trends in I & E awards for 1977 and 1978 are compared below:

Table 4.2: I&E Components of IPAVS Sub-Grants Awarded in 1977 and 1978

Year	Total No. Sub-Grants Awarded	Total No. Sub-Grants With I&E	Total I&E Sub-Grant Funds	% I&E of Sub-Grant Funds	Average Budget per I&E Grant
1977	73	40	\$157,373	4%	\$3,934
1978	53*	33	\$109,982	4%	\$3,333

*Includes one sub-grant cancelled in 1978

While the percentage of sub-grant funds expended on I & E activities remained the same during 1977 and 1978 (4%), total I & E expenditures declined reflecting the lower number of sub-grants awarded in 1978. Another factor in the decline is IPAVS's continuing insistence on efficient and cost-effective programs.

COUNSELING AND INFORMED CONSENT ACTIVITIES

In 1977, IPAVS developed informed consent guidelines which were sent to all sub-grant project directors to assist them in developing their counselling programs. The purpose of the guidelines was to insure the protection of individual rights by standardizing requirements necessary for informed consent. The guidelines are routinely included in the contract packages of all new sub-grantees and are in compliance with USAID requirements established in 1977.

In 1978, a survey of all our service sub-grants showed them to be nearly 100% in compliance. As of November 1, 1978, when the survey was completed, 90% of our sub-grantees were in full compliance, 5% were in partial compliance and 5% had not yet submitted their informed consent materials. Currently, IPAVS is actively working with these 10% to ensure complete compliance within a short time.

The guidelines prepared by IPAVS incorporated the following six points:

1. The acceptor is aware that there are temporary methods of contraception that are available to him/her instead of sterilization
2. The acceptor is aware that sterilization is a surgical procedure and the details of the operation and its effects

have been discussed with him/her by the physician.

- 3. The acceptor is aware of the possible risks involved in the procedure as explained by his/her physician.
- 4. The acceptor is aware that if the operation is successful, he/she will no longer have any more children.
- 5. The acceptor is aware the procedure is irreversible.
- 6. The acceptor is aware that he or she can refuse the operation and no medical, health, or other services or benefits will be withheld from him/her as a result.

IPAVS has also prepared special informed consent guidelines for pre-literate people. Sub-grant compliance to these special guidelines also nears the 100% level.

CONFERENCES

Effective communication is critical to all IPAVS's efforts to advance the acceptance and availability of voluntary surgical contraception. One communication objective of IPAVS's overall management plan is the promotion and sponsorship of forums for responsible discussions via national, regional and international conferences. Conferences are specifically designed to bring together professionals with health and family planning expertise, experience, or concerns, and international leaders from a variety of disciplines that have impact on the climate of acceptance and availability of voluntary sterilization. Free and open discussion and exchange of ideas, experiences, and knowledge at these forums often generate research and innovation in surgical contraception technology, policy development, and programmatic options.

At the national and regional levels, conferences aid the implementation or expansion of voluntary sterilization programs by encouraging developing countries to assess unmet needs for and feasibility

of these services. They also help identify and encourage local leadership who can advance the surgical contraception movement, often by formation of national associations for voluntary sterilization.

Regional conferences, in addition, serve to facilitate co-ordination of activities among countries with similar problems in a given area. As the term implies, international conferences are more global, both in scope and effect.

During 1978, IPAVS funded, co-funded, or participated in 12 conferences and other major meetings in 10 countries. Commencing with a national conference in Bangladesh, conference activities culminated in the First Latin American Regional Seminar on Permanent Fertility Limitation and Its Effects on Health. All conference activity during 1978 leads into and lends focus to the Fourth International Conference on Voluntary Sterilization.

A brief summary of IPAVS conference activity during 1978 is given below:

Second National Conference on Voluntary Sterilization
Dacca, Bangladesh, January 21-22, 1978

Sponsored by IPAVS and hosted by the Bangladesh Association for Voluntary Sterilization, the goal of this conference was to acquaint rural physicians in Bangladesh with the possibility of incorporating voluntary sterilization within their family planning programs. It sought to motivate the physicians to gain training in clinical techniques of surgical contraception and to seek assistance in offering these services in their localities. One hundred and twenty rural physicians attended the four scientific sessions and four guest lectures on the place of voluntary sterilization in family planning and total health care programs.

Program Planning Committee Meetings for the First Latin American Regional Seminar on Permanent Fertility Limitation and its Effects on Health

San Salvador, El Salvador May 23-24 and September 28, 1978

Representatives from IPAVS and several Latin American family planning and related associations met in San Salvador in May and again in September of 1978 to prepare the program and logistics for this Seminar which was scheduled for December. The meeting in May defined the scope, purpose, and level of participation, as well as objectives of the conference, and members explored suitable conference sites. In September, the Planning Committee reviewed arrangements that had been made for the conference, reviewed and approved recommended speakers, and finalized the program.

Second National Conference on Voluntary Sterilization
Seoul, Korea, May 26-27, 1978

Approximately 250 health and medical professionals, primarily physicians, attended this conference. Sponsored by IPAVS, which funded three of the international speakers, and hosted by the Korean AVS, the conference promoted voluntary sterilization as an integral part of the public health and family planning program of Korea. In addition, it sought to motivate physicians to seek training in surgical contraception techniques and to assist in developing voluntary sterilization programs in their own areas.

First National Conference on Surgical Contraception
Kandy, Sri Lanka, June 17-19, 1978

Sri Lanka AVS was founded in 1974 for the primary purpose of co-operating with and assisting the Government of Sri Lanka in its population planning and family health programs. It hosted the country's First National Conference on Surgical Contraception in Co-operation with IPAVS. The conference was designed to serve as a forum for health and social science professionals seeking to implement surgical contraception programs in Sri Lanka. Participating in the program's

ten sessions were approximately 150 physicians and health professionals, government officials, social workers, university students and interested individuals. Thirteen delegates from foreign countries shared current knowledge regarding advances in voluntary sterilization with those in a position to implement or promote these programs within Sri Lanka.

First Honduran Seminar on Reproductive Health and Surgical Contraception
Tegucigalpa, Honduras, August 4-5 1978

In conjunction with the Honduran Ministry of Public Health, the Honduran Association of Family Planning, and the Honduran Association of Obstetricians and Gynecologists acting as hosts, IPAVS sponsored and funded three international speakers to the First Honduran Seminar on Reproductive Health and Surgical Contraception. Dr. Lubell delivered a combined address for himself and Dr. Marilyn E. Schima on the topic, "Implications of Surgical Contraception for Family Health." Objectives of the conference were to interest the 130 public health physicians, gynecologists, urologists, Ob/Gyn residents, nurses and social workers in the concept of voluntary sterilization and to have the conference serve as the basis for the development of a national voluntary sterilization program.

Second Annual Meeting of the Australia AVS
Melbourne, Australia, October 29, 1978

Melbourne University was the site of the Second Australian Symposium on Voluntary Sterilization sponsored by the Australian AVS, a new member of the World Federation of Associations for Voluntary Sterilization. The programs of this day-long meeting consisted of four continuous sessions which covered the history of voluntary sterilization and its medico-legal, psycho-social aspects. IPAVS funded the conference's international guest-speaker, an eminent physician and expert on sterilization who addressed the audience at both the first and last sessions of the meeting and shared his expertise with them.

International Symposium on Sterilization
Rome, Italy, November 10-12, 1978

The Family Planning Center of the University of Rome organized this symposium to enlighten gynecologists, urologists, social workers, lawyers and theologians, and others who attended the conference, about surgical contraception. Passage of an abortion law in Italy in 1978 nullified a portion of the Penal Code which had prohibited sterilization, an almost unknown procedure there.

IPAVS was among the organizations of international experts invited to participate in the conference. Dr. Lubell spoke on the worldwide success of voluntary sterilization and illustrated his points with a slide presentation. IPAVS also furnished a bibliography of its available audio-visual materials, and provided copies of its publication, New Advances in Sterilization.

Second National Conference of the National Association of Voluntary Sterilization of India
Patna, India, November 6-9, 1978

More than 150 obstetricians, gynecologists and other prominent physicians concerned with family welfare from all over India (particularly the most populous northeastern states,) members of the NAVSI, and representatives from other national associations attended this Second National Conference on Voluntary Sterilization. The Conference was sponsored by NAVSI, an organization that has played a leadership role in advancing voluntary surgical contraception in India. The Governor of Bihar officiated and spoke of the need to provide voluntary surgical contraception services in remote villages largely isolated from the mainstream of Indian life. He called for co-operation and participation of voluntary social organizations and of NAVSs in the national family planning program. IPAVS funded 11 international participants.

XVII Congress of the Union of Arab Doctors
Rabat, Morocco, November 20-22, 1978

The annual meeting of the Union of Arab Doctors, comprised of medical organizations from all 13 Arab countries, was held in Rabat, Morocco. More than 1,000 medical and health professionals attended its 26 scientific sessions. Two representatives from IPAVS, several IPAVS sub-grantees, and a number of physicians engaged in forming NAVS committees within family planning associations in their own countries, were present. IPAVS funded ten participants from six countries, six of whom presented papers on voluntary surgical contraception. All ten IPAVS-funded delegates participated in a round-table scientific session and gave brief presentations of their own field work, which evoked provocative and stimulating questions from the audience. More than 200 people attended the session, the most widely attended and successful of the conference's scientific sessions.

Another successful outcome of this meeting was the formal organization of an Arab Federation of Associations for Voluntary Sterilization. Sixteen physicians attending the Congress completed arrangements for formation of the Federation, adopted by-laws, and elected a General Secretary. It is anticipated that the next meeting of the AFAVS will be held in Korea in May, coincident with the Fourth International Conference on Voluntary Sterilization, and that application will be made for membership in WFAVS.

First Latin American Regional Seminar on Permanent Fertility Limitation and Its Effects on Health

San Salvador, El Salvador, December 6-8, 1978

More than 100 delegates from 19 countries, representing most of the major countries of the hemisphere, attended this First Latin American Seminar, sponsored by IPAVS and co-ordinated by the Asociacion Demografica Salvadorena. The inaugural address by the Vice-President of El Salvador and the closing presentation by the Minister of Health of

that Republic indicated official approval given this conference by the Government of El Salvador.

Among the topics covered at the plenary sessions and workshops of this three-day conference were the historical and legal foundations of permanent fertility limitation, its status and demographic impact in various Latin American countries, its benefits to maternal-child health, and the problems and opportunities in program development. An audio-visual program and several round-table discussions dealing with attitudes toward voluntary sterilization completed this very successful regional event.

Fourth International Conference on Voluntary Sterilization

A tri-annual, major international leadership conference has become traditional with IPAVS, and the Fourth International Conference on Voluntary Sterilization is now in the final stages of planning. To be held in Seoul, Korea, May 7-10, 1979, it will focus on the multi-disciplinary influences affecting surgical contraception as an integral and essential component of national family planning and health care programs. This emphasis is a natural progression from the Second International Conference which dealt with surgical and technical aspects of voluntary sterilization, and from the Third International Conference which examined advances in technology and the crucial role of the physician in initiating, developing and implementing voluntary sterilization programs. Conference participants will include 350 to 500 key international program planners, administrators, educators, researchers, physicians, lawyers, political leaders and policy-makers in positions to make critical advances in voluntary sterilization at national levels. The conference structure will consist of seven plenary and a special session on specific topics relating to voluntary sterilization. Eleven 2-½ hour task forces, scheduled for two consecutive days, will complement and expand upon

themes, topics and issues introduced at the main sessions. They will be goal-oriented to generate recommendations for research and programmatic options of value to the entire professional community involved with voluntary sterilization programs. Outcomes will be reported at the closing plenary session and a press conference will be held on the last day of the Conference for representatives of major news services. Proceedings will be published and distributed to professional and public leaders worldwide.

Since 1973, the number of conferences has increased sixfold, but not all attempt to reach conclusions or formulate action. Often the benefits are in the opportunity to compare and contrast experiences, share knowledge, generate ideas, and provide perspectives. Since voluntary sterilization now surpasses all other methods in new acceptors for fertility management, conferences at all levels take on added significance. Not only do they serve to pass along current information to the professional, but they also help to heighten public understanding of the role of voluntary sterilization in family planning and health care delivery systems. Conferences are, and will continue to be, an important component of IPAVS activity.

LIBRARY ACTIVITIES

The Library has completed several projects during 1978 that have improved accessibility to its materials and consequently its service. The major projects completed during 1978 include:

Projects for Increased Accessibility to Materials

1. Changeover of the entire reference, book, and audio-visual collection to standard subject classification systems.
2. Reorganization of IEC and patient education materials by country, organization, and sub-grant.

3. Organization of Information and Education and Training curricula by country and sub-grant, including a picture file by country and sub-grant.
4. Revision of catalog card subject headings to speed access to important areas of the collection.

Table 4.3: Growth of IPAVS Library Collection 1977-1978

ITEM	12/31/77	12/31/78	% INCREASE
Books	950 volumes	1,350 volumes	42%
Serials	144 titles	182 titles	26%
*Reprints	2,750 articles (9/1/76)	3,100 articles	12%
Audio-Visuals	68 items	88 items	29%

*Reprints: figures adjusted for relocation of catalogued journal articles, annual reports and IEC materials.

IPAVS PUBLICATIONS

Newsletters

In 1978, the IPAVS Newsletter began bimonthly publication to bring its total issues to six per year, an increase of two over the 1977 schedule. Included in the six 1978 issues was a special eight page technical and scientific edition in September prepared by the WFAVS.

The Newsletter provides condensed information on recent events in the field, significant program accomplishments, scientific advances and other matters relating to surgical contraception. The previous standard publication run of 5,000 was maintained in 1978 for the regular issues, and was increased by 1,000 for the special issue.

The Newsletter is sent to all sub-grantees, many of whom receive multiple copies for distribution in their area, to approximately 2,400 individuals on the IPAVS mailing list, and to various individuals who write in requesting information. Copies are always made available at various conferences, meetings, and exhibits attended by IPAVS directors or staff.

Other Materials

Printed public information materials and other documents are being developed and translated into French, Spanish and Arabic.

Chapter 5

IPAVS AND NATIONAL LEADERSHIP ORGANIZATIONS

National associations are rapidly becoming the cornerstone of the movement to make surgical contraception acceptable and available throughout the world. Patterned after the U.S. Association for Voluntary Sterilization -- voluntary, democratic, and non-governmental -- these associations are true, indigenous leadership organizations that combine the qualities of catalyst and spearhead in their efforts to focus attention of national governments on the needs of their peoples. Identifying and exploring the unmet needs and investigating new approaches to stimulate acceptance of voluntary sterilization on a national scale, the NAVS has become a flexible, sensitive instrument of change. IPAVS has been committed to the support of these leadership organizations as a key objective of its international program since 1973 when the Second International Conference on Voluntary Sterilization recommended their development.

Through a volunteer network made up of members and supporters, the associations serve as a base for in-country activities, with key individuals from health and related professions working together for the inclusion of voluntary sterilization into the overall national health care delivery systems of their countries. In five years, the number of legally registered national associations dedicated exclusively to the promotion of voluntary sterilization (NAVSS) grew from 2 to 20 as can be seen in Table 5.1, below. Much of this growth is due to the support and technical assistance provided by IPAVS.

Table 5.1: Total Number of Countries with Legally Registered NAVSs, 1973-1978

	1973	1974	1975	1976	1977	1978
Developing Countries	1	5	14	14	12	15
Developed Countries	1	1	2	4	4	5
TOTAL	2	6	16	18	16*	20

*This drop in the number of associations legally registered resulted from two countries, Iran and Costa Rica, letting their registrations lapse after the first year due to organizational difficulties.

In addition, IPAVS is currently working with groups and/or individual leaders in 41 countries that have shown interest in promoting voluntary sterilization through national organizations.

National associations originated because of the reluctance of many governments and established family planning agencies to support and promote voluntary sterilization on a national basis. During the last few years, however, some governments and many established family planning groups have reversed their positions. For this reason, it became necessary for each local leadership group to carefully assess the domestic situation, and determine the most effective means of promoting voluntary sterilization. In some cases, an established organization (i.e. medical society, voluntary family planning agency, etc.) worked actively to promote voluntary sterilization within its existing structure through a voluntary sterilization committee. IPAVS works closely with a number of national organizations that have

formed such committees. Table 5.2 depicts the growth of these committees since 1973.

Table 5.2: Total Number of Countries with Organizations That Have Formed Voluntary Sterilization Committees, 1973-1978

	1973	1974	1975	1976	1977	1978
Developing Countries	0	0	0	1	5	7

IPAVS FUNDING OF NATIONAL ASSOCIATIONS

As part of its ongoing program, IPAVS offers guidance to emerging associations in developing countries and, once an association has been formed, provides technical and financial assistance for the development and implementation of operational and program objectives.

During 1978, IPAVS supported national association sub-grants in 11 countries: Bangladesh, Egypt, France, Indonesia, Korea, Philippines, Lanka, Sudan, Taiwan, Thailand, and Turkey. During this period, nine NAVS continuation administrative grants were developed and awarded, totaling \$348,573. This represents a 12% increase over the comparative figure for 1977. Of these nine grants, three were for second-year funding, three for third-year funding, two for four-year funding, and one was for fifth-year support. As can be seen in Table 5.3, there has been a steady increase, since 1973, in the amount of financial assistance IPAVS has awarded each year to national associations.

Table 5³: Total IPAVS Financial Assistance to NAVSs for Administrative Support Awarded by Year, 1973-1978

YEAR	1973	1974	1975	1976	1977	1978
Total amount of funds awarded to NAVSs	0	\$35,340	\$94,390	\$173,397	\$310,084	\$348,573

The tremendous growth pattern between 1976-1977 reflects the maturing of a number of associations that have moved from small, first-year programs to more developed and ambitious second- and third-year programs. IPAVS funding of NAVSs in 1978 leveled off to some extent, but is expected to resume growth in the future.

National associations, after developing effective management capability and gaining the support of the professional community, have begun developing comprehensive, sophisticated, action-oriented programs. To encourage and support this kind of program growth, IPAVS awarded special NAVS project sub-grants for service, training, information and education, equipment repair and maintenance, and branch development programs. In 1978, 12 special project sub-grants were awarded to national associations for a total of \$512,246. This compares with 10 special project sub-grants for \$465,147 in 1977, as shown in Table 5.4., and it represents a 10% increase over 1977.

Table 5.4: IPAVS Special Project Funds Awarded to NAVSs, by Year, 1973-1978

YEAR	1973	1974	1975	1976	1977	1978
Amount of supplemental funds provided	0	\$141,390	\$99,430	\$177,856	\$465,147	\$512,246
No. of supplemental grants	0	1	2	3	10	12

Overall growth of IPAVS support to national associations has been steady, as can be seen by the data presented in Table 5.5.

Table 5.5: IPAVS Total (Core & Supplemental) Financial Assistance to NAVSs, by Year, 1973-1978

YEAR	1973	1974	1975	1976	1977	1978
Total Amount in \$	0	176,730	193,820	351,253	775,231	860,819
Total No. of Grants	0	4	11	13	20	24

The total amount of IPAVS financial support, including funds for both the core administrative and supplemental programs to national associations, totaled \$860,819 in 1978, an 11% increase over the amount in 1977.

HOW NATIONAL LEADERSHIP ORGANIZATIONS INFLUENCE CHANGE

National association activities can and do influence the incorporation of surgical contraception into the total family planning and health service programs of their countries. The following examples clearly demonstrate their potential.

Egypt: The Egyptian Fertility Control Society (EFCS) has been working behind the scenes to gain acceptance for Voluntary Sterilization Contraception in Egypt. At the Society's Fifth Annual Meeting, a plan was adopted and endorsed by the Government establishing an EFCS-coordinated national training and service program through 12 top medical facilities in Egypt. In addition, the Conference, with Government recognition, adopted a statement endorsing voluntary surgical contraception

as one means to reduce the problem of high parity.

The EFCS's Voluntary Surgical Contraception national training and service program is designed to enhance the Egyptian national family planning program. The primary activities of this program will be to provide mini-laparotomy and laparoscopy training for all qualified gynecologists from the Ministry of Health and governmental district hospitals. It is estimated that approximately 340 Ob/Gyns are in need of such training. In addition to training, appropriate equipment will be provided to facilities with trained staff for the establishment of high quality voluntary surgical contraception service programs.

Complementary to the national training/service program, EFCS will design and implement a national information and education program for the general public on the health hazards of high parity and the importance of surgical contraception as a method of fertility management. EFCS has been given the responsibility by the Government for coordinating the training/service and I&E programs as well as the importation and distribution of medical equipment for both the training institutions and the training graduates facility.

Bangladesh: The Bangladesh Association for Voluntary Sterilization (BAVS) has been in operation for four years, and has developed a network of 18 BAVS branch groups throughout the country. BAVS has emphasized the establishment of a model demonstration service facility and the provision of technical assistance and training to groups desirous of establishing local service clinics. Through their model clinic and several extension service projects, BAVS has effectively demonstrated that the public will seek surgical contraception if high quality services are accessible. BAVS is currently working to replicate the service model in the 18 locations throughout Bangladesh. This activity has helped to stimulate the Bangladesh government to include voluntary surgical contraception in their national family planning service delivery program. BAVS has also made headway in the development of I&E materials and counseling strategies that have had an impact on the knowledge that professionals and the public have regarding voluntary surgical contraception. The innovative efforts of BAVS have demonstrated to the government the need for and feasibility of including voluntary surgical contraception in the national health program and the government has now accepted primary responsibility for service provision in Bangladesh. However, the government still relies on BAVS for certain essential inputs the government is not able to assume, such as specialized professional training and the development of medical standards regarding voluntary surgical contraception.

Korea: Since voluntary sterilization is widely available and acceptable in Korea, the Korean Association for Voluntary Sterilization (KAVS) has been a proving ground for innovative voluntary sterilization activities. KAVS established an endoscopic equipment maintenance and repair center which currently operates a routine and emergency maintenance and repair program nationwide. In addition, KAVS developed and implemented two demonstration projects concerning Voluntary Surgical Contraception complications and vasectomy reversal that were necessary for a truly strong and institutionalized national Voluntary Surgical Contraception program in Korea. It is anticipated that the Korean Government will assume responsibility for all three of these projects in the near future. KAVS is also instrumental in providing professional voluntary surgical contraception training and is working hand-in-hand with the national health program to train appropriate public and private physicians. Furthermore, the Association has been able to make good progress in designing and implementing an I&E program for professionals, making use of professional print media, seminars and other appropriate sources to spread the word concerning voluntary sterilization.

Indonesia: Although voluntary surgical contraception is a sensitive subject in Indonesia and is not an official part of the national family planning program, the government has designated the Indonesian Society for Voluntary Sterilization as the national coordinator of surgical contraceptive activities in Indonesia. Because of this relationship with the national family planning government organization, the Society has gotten cooperation from various government agencies in their effort to popularize and integrate voluntary sterilization into the Indonesian health system.

The major input of the Society has been the development and organization of a national Voluntary Surgical Contraception manpower training program and major Indonesian medical teaching centers have developed standardized trainee selection and certification criteria, medical guidelines, informed consent materials, and a curriculum for the training program. It is also responsible for the coordination of Voluntary Surgical Contraception information to the Indonesian medical profession, on a routine basis, in an effort to popularize Voluntary Surgical Contraception and educate professionals about the details and implications of surgical contraception.

Finally, much effort is being made by the Society to strengthen its 11 branches throughout Indonesia in order to have a more grass-roots orientation.

These examples and others listed in Table 5.6 show that each association has assumed its own identity and each has developed and implemented programs which have responded to individual national concerns and priorities.

Specific activities carried out by each IPAUS-funded association are listed in Appendix C

As expected, the formation, development, and funding of national associations has proved to be a time-consuming process, requiring much technical assistance from IPAUS. Helping associations to define their plans of action has been a major IPAUS technical assistance activity and has been valuable in accomplishing smooth and effective operations of the associations. IPAUS made site visits in 1978 to eight of its funded national associations and to eight additional leadership organizations to offer encouragement, direction and technical assistance in their development efforts.

SUMMARY

The International Project has recently noted increased support by established family planning or medical groups for voluntary sterilization. If these groups establish a formal means to actively support voluntary sterilization through their existing organizations, adequate national focus can be given to voluntary sterilization without establishing a separate organization such as NAVS. The choice between these two alternatives must be made at the local level. However, both models have proven to be an effective means to promote the integration of voluntary sterilization into the national health program.

Chapter 6

WORLD FEDERATION OF ASSOCIATIONS FOR VOLUNTARY STERILIZATION

As the number of national associations grew and matured, many recognized the need for a unifying forum for the voluntary sterilization movement to provide national representation and coordination at the international level. In answer to this need, the World Federation of Associations for Voluntary Sterilization (WFAVS) was formed in 1975. Provision of the necessary logistical and staff support for the organizational development of the Federation and the implementation of its programs has been a major IPAVS activity.

Since its inception in 1975, the Federation has promoted voluntary sterilization at the international level by:

- Developing and publicizing policy on issues related to voluntary sterilization;
- Establishing standards for voluntary sterilization services, education, training, data collection, and equipment maintenance;
- Providing information to professionals and members of the Federation regarding developments in voluntary sterilization;
- Encouraging research and demonstration projects in voluntary sterilization, including the medical, psychological, and cultural aspects, and disseminating the research findings throughout the international health community;
- Serving as a liaison between its members and other related health organizations and institutions.

MEMBERSHIP

At the national level, the Federation works through its member

associations which are dedicated to promoting voluntary surgical contraception in their own countries. Other Members are regional and international organizations interested or involved in advancing voluntary surgical contraception as a method of fertility management. There are currently 22 member associations in the Federation; 16 are from developing countries and 6 from developed countries. This membership represents nearly 13,000 individuals with a shared concern for the promotion of voluntary sterilization.

Growth of the Federation since its inception is depicted in Table 6.1. New applications for membership will be considered at the WFAVS Fifth General Assembly which will be held in Korea in May of 1979.

Table 6.1: Growth of WFAVS Membership

Type of Association	1975	1976	1977	1978
National	6	10	14	16
Affiliate	0	0	2	5
Regional	1*	1*	0	0
Associate	1**	0	0	1
TOTAL	8	11	16	22

*Regional association was anticipated, but resigned in 1977 as it was unable to register.

**Netherlands associate member withdrew in 1976.

The WFAVS Administrative Office at IPAVS headquarters has acted as communications liaison to prospective members as well as to the whole network of Federation members. The office provides information, materials of all types, and technical assistance. IPAVS staff has refined the membership guidelines manual for the Federation. In addition, a technical assistance module was developed for the formation of committee affiliate associations. For new associations, a package of articles and resource materials was compiled for use by organizations in their early stages of development.

To encourage the expansion of the Federation's membership, it was decided that certain documents such as the WFAVS by-laws and other informational materials be translated into Arabic, French and Spanish. A draft printing of the WFAVS by-laws in Arabic was distributed at the XVII Congress of the Union of Arab Doctors in Rabat, Morocco, November 20-22, 1978 where the formal organization of the Arab Federation of Associations for Voluntary Sterilization took place. Organizations from seven countries comprise its membership. (See Appendix E.)

COMMITTEE ACTIVITIES

A special effort has been made to establish a strong committee structure to implement the multi-faceted program of the Federation. In 1976, the Third General Assembly adopted a broad series of program strategies recommended by the WFAVS Program Committee. The Assembly provided a mandate for the formation of the necessary committees to implement an overall program. In 1977, committees were organized, members appointed, and purposes, responsibilities and procedures defined.

In 1978, the task was to translate these efforts into program action. During the two days prior to the Fourth General Assembly, held in

Bangkok, Thailand, in February, the committees critically reviewed their purposes in order to develop plans of action for 1978. Highlights of the major recommendations from the WFAVS action committees and the progress are:

- Scientific Committee: The Committee defined as its purpose to locate, review and disseminate information on developments in male and female sterilization; encourage and stimulate research and demonstration projects by independent researchers on relevant aspects of voluntary sterilization (medical, social, political, legal, economic, sociological, etc.); and establish working relationships with other agencies which have access to scientific data on sterilization. A special WFAVS Report was prepared by the Scientific Committee to update the purpose and activities of major agencies involved in research. A summary of research developments in transcervical approach to female sterilization and potential reversibility of male sterilization procedures was included. IPAVS published the report for distribution to 5,000 individuals and agencies interested or involved in voluntary sterilization.

The Committee is currently developing a list of scientific issues on sterilization and plans to present for adoption a number of scientific policy statements to the May 1979 General Assembly.

- Joint Committee on Training & Equipment: The Committee set as its goal the provision of practical information on voluntary sterilization training equipment to the medical community. The first step was to gather base-line data on existing training programs and needs in member countries and then to evaluate these data in order to set minimum training standards for all levels of personnel. The Committee developed a questionnaire to gather initial information and is now in the process of analyzing the responses. A report will be presented to the Fifth General Assembly.
- Information and Education Committee: The Committee's purpose is to develop an I&E system for the Federation which will assist member associations and other international bodies to understand the importance of I&E programs in voluntary sterilization service delivery. The Committee is currently conducting an inventory of I&E approaches, activities and materials of member associations. From this survey, the Committee will make overall recommendations for I&E strategies.

- Committee on Data Collection: The Committee has determined that its primary responsibility will be to accumulate world-wide data on the demand for sterilization and on facilities and manpower available to meet the demand. In addition, the Committee hopes to assess needs, successes and negative influences. The purpose of these data and their evaluation will be to convince policy makers and international agencies of the magnitude of support needed for sterilization activities. This is indeed an ambitious goal and will take considerable time to implement.

To date the Committee has developed a position paper outlining its plans to accomplish this objective. Initially, the Committee will coordinate with such organizations as IFRP, WHO, IPPF, USAID, and UNFPA in an effort to standardize statistics across the borders. From these dialogues the Committee hopes to develop guidelines for data collection tools.

- Conference Committee: The Committee developed recommendations for format, approach, content and participants for the IPAVS Fourth International Conference and submitted its recommendations to IPAVS in February 1978. These recommendations provided a base for the IPAVS Conference Planning Committee.
- Expert Group on Nomenclature: This group was mandated to obtain information on the meaning and usage of the word "sterilization" in languages other than English. The Committee developed a questionnaire and distributed it to Federation members, soliciting information on the understanding and use of the word. Based on the results, the Committee will make recommendations to the next General Assembly for alternative and culturally acceptable nomenclature.
- Expert Group on Voluntary vs. Involuntary Sterilization: This group was mandated to explore voluntary versus involuntary sterilization practices, the meaning of compulsion, and the implications of the use of incentives and disincentives. It is considered extremely important that these issues be investigated, particularly in regard to non-literate populations.

In order to meet its mandate, over the next year, the Committee, through position papers prepared by specialized consultants, plans to formulate broad definitions of literacy, illiteracy, and voluntary, involuntary, and coerced sterilization. The Committee will also explore elements of proper counseling and informed consent, and will develop guidelines for ensuring voluntarism. Statements of the Federation on the

issues will have significant weight in defining this critical area, and in providing crucial interpretations and guidance to the national and international community.

To co-ordinate activities of the Committees, IPAVS staff has developed a work plan for monitoring the committees' activities and keeping their activities on schedule as mandated by the General Assembly and in accordance with the WFAVS By-laws. In addition, IPAVS has designed a system for facilitating communications between the Executive Secretary, the Officers, the Committee Chairperson and committee members.

To help WFAVS maintain a strong committee system, IPAVS has refined the Committee Procedures Manual which defines their purposes, responsibilities and procedures. Under these guidelines, committees' memberships and responsibilities are reviewed and updated as necessary.

OFFICIAL AND COLLABORATIVE RELATIONSHIPS

During 1978, the WFAVS officers and IPAVS staff concentrated on forming important communications links with other health and social organizations. These efforts have produced concrete results in that the Federation now has official and collaborative relationships with sixteen organizations:

- American Association of Gynecological Laparoscopists (AAGL)
- Association for Voluntary Action Scholars (AVAS)
- Family Planning International Assistance (EPIA)
- International Federation of Family Health Research (IFFHR)
- International Fertility Research Program (IFRP)
- International Planned Parenthood Federation (IPPF)
- International Union for Health Education (IUHE)
- Pan American Health Organization
- Population Crisis Committee

- Population Information Program of George Washington University (POPINFORM)
- Population Roundtable
- Program for Applied Research on Fertility Regulation (PARFR)
- Program for Introduction and Adaptation of Contraceptive Technology (PIACT)
- United Nations Fund for Population Activities (UNFPA)
- World Federation of Public Health Associations (WFPHA)
- World Health Organization (WHO)

Non-governmental status with the United Nations community is an important part of the process of gaining official recognition and coordination with other agencies at the international level. The WFAVS officers and Executive Secretary have been actively involved during the year in establishing these important contacts and in opening up lines of communication. The possibility of NGO status with other agencies, specifically WHO and ECOSOC has been investigated. Guidelines and application forms have been obtained and will be submitted to the respective NGO review committees.

CONCLUSION:

The Federation has grown rapidly in its first four years; the Federation officers, committees, members and staff have worked hard to develop a viable and purposeful organization. With its past accomplishments and future goals as well as the growing prestige of the Federation, there is every reason to believe that it will continue to grow, taking its place as a recognized leader in the international voluntary sterilization movement.

Chapter 7

PROGRAM SUPPORT FUNCTIONS FOR MANAGEMENT OF SUB-GRANT ACTIVITIES

Since 80% of the IPAVS budget goes to sub-grant and related programs activities, (see page 1-3) a comprehensive management and support system for these activities is crucial. IPAVS accomplishes this through a combination of internal monitoring systems, routine reports from sub-grantees, and regular site visits to offer on-site technical assistance. With the addition of the computer acquired in 1978, IPAVS hopes to provide improved reviews of all sub-grant activities in order to be alert to problems as they develop and to offer assistance as needed. A brief description of the various parts of this management system follows.

THE NEW COMPUTER INFORMATION SYSTEM

The creation of a computerized Management Information System (MIS) was first proposed in 1977. A management study by the Evaluation Office clearly indicated an urgent need to implement a computerized data processing system if IPAVS was to continue to maintain a high standard of sub-grant support and technical assistance, and to continue efficient administrative and program planning operations. IPAVS' information needs were seen as follows:

- more complete, easily and quickly accessible data for use in planning and decision-making in-house and for dissemination to our funders and the public;
- capability of retrospective studies of sub-grant activities including trend analysis;

- improved statistical data processing and analysis;
- more comprehensive financial information;
- commodities tracking and inventory;
- computerized mailing list;
- routine reports such as:
 - Sub-grant status reports
 - Equipment reports of amounts, types and location
 - National Association status reports
 - Conference grant status reports
 - Proposal status reports
- special reports such as:
 - publications that provide information to the professional community
 - IPAVS special reporting requirements for funders
 - special management problems
 - administrative follow-up lists
 - mailing list labels

Research was conducted to select the most suitable computer hardware based on the following criteria:

- a) The system must provide management information in a timely and efficient manner.
- b) The system must be easy to operate and simple to understand and use.
- c) The system must be within certain cost guidelines as developed by management.

After a year-long study of the computer industry, the Evaluation Office recommended the Sperry Univac BC/7 mini-computer as unique in meeting IPAVS' computer system needs. This computer has the capacity of saving up to 5 million pieces of information. It is operated by an English-like language called ESCORT and the total yearly cost of such a system is about \$20,000 (see Appendix G) for the first three years and substantially less subsequently.

IPAVS purchased the machine in March, 1978, and in that same month hired a Data Processing Manager for the computerization project. The major tasks during the initial nine months of the project were to:

1. Test and become familiar with the functions of the machine;
2. Select appropriate variables for computerization and create logical file structures to contain them;
3. Collect the information for each variable from the most reliable sources;
4. Key punch and store the data in the various files in the computer;
5. Design and implement the routine updating procedures for new information;
6. Produce coding manuals to describe the variables contained in each file.

To date, 13 files have been created for data storage; several other operational files have been created to make the calculations needed in the programs developed to access information; and more than 600 variables have been selected, coded, keypunched, and saved in the computer. A brief explanation of each file and its variables follows: (Appendix ____ contains a detailed description of the variables in each file.)

1. **GRANT MASTER FILE (46 variables):**
This file contains the basic programmatic information about each sub-grant including name of the project director, project address, program components, service and training objectives, etc.
2. **GRANTS MONITOR FILE (36 variables):**
This file contains all critical dates in the life cycle of each grant including the effective date, the operational date, the termination date, and dates of all administrative extensions. This file is of great importance because of its use in determining the status of each grant (i.e., whether effective, expired or inactive).
3. **FINANCIAL MASTER FILE (56 variables)**
This file contains budget and expenditure information collected

from financial reports submitted by sub-grantees.

4. **FINANCIAL MONITOR FILE (47 variables):**
This file contains:
 - a) Receiving dates and reporting period of the financial reports;
 - b) Amount and dates of each fund-transfer or reimbursement;
 - c) Status of audit process.
5. **NAVS FILE (65 variables):**
This file contains administrative information on all NAVSs such as names of officers and committee structures, plus basic sub-grant information on core and supplemental grants.
6. **EQUIPMENT FILE (21 variables):**
This file contains the ordering, shipping and receiving information on every piece of equipment provided by IPAVS to our sub-grantees through sub-grants, small grants and special equipment grants.
7. **SERVICE STATISTICS FILE (78 variables):**
This file contains information on every service statistics form we receive from sub-grantees. Data stored in the computer include the number and type of procedures performed by the sub-grant during each reporting period as well as age and parity data of the acceptors.
8. **TRAINEE RECORD FILE (36 variables):**
This file contains the information on every trainee form we receive from sub-grantees. Data stored include the trainee's name, professional status, specialization, training site, type of training, etc.
9. **SMALL GRANT FILE (17 variables):**
This file contains basic programmatic and accounting information for all the small grants awarded by IPAVS.
10. **CONFERENCE GRANT FILE (43 variables):**
This file contains programmatic and accounting information for the conference grants awarded by IPAVS.
11. **KOREAN CONFERENCE FILE (40 variables):**
This file includes information on all persons invited to the Korean Conference, their expertise, and their role in the conference.
12. **REPORT MONITORING FILE (I) (51 variables):**

This file includes reporting requirements for each sub-grant and and receipt dates of reports submitted by sub-grantees. This file is used to keep track of overdue reports and to monitor the reporting rate of all grantees.

13. REPORT MONITORING FILE (II) (20 variables):

This file is a continuation of the previous file due to the limitation in the amount of data that can be stored in one file.

After the initial collection and input of data which took place from April through July, a system was established to co-ordinate data collection from respective LAVS offices to ensure prompt input of data into the computer. This system utilized special forms for supplying new information and updating current information. Based on the information currently stored in the computer, we have developed a number of programs which generate information frequently requested by staff. The following are a few examples of these programs.

<u>Program Name</u>	<u>Frequency</u>	<u>Use</u>
1. STAFREVIEW	As needed	Produces background information Office for sub-grant review meetings; contains items on procedures performed, % of objectives achieved, % of budgeted dollars spent, reporting status for each sub-grant to be reviewed.
2. SHIPCHEK	Once/Month (Beginning)	Lists all equipment items which have been ordered for more than 90 days but have not yet been shipped.
3. AGEBREAK	As needed	Produces age breakdown of voluntary sterilization acceptors by country, region, grant, quarter, or year.
4. PRCBREAK	As needed	Produces procedure breakdown of voluntary sterilization acceptors by country, region, grant, quarter, or year.
5. REGNDIST	As needed	Gives geographic distribution of currently active sub-grants.

6. PROPREQU	Once/Month	Lists grants 4 months from termination for which we have not requested continuation proposals.
7. PROPFU	Once/Month (beginning)	Lists grants 3 months from termination for which we have not received continuation proposals.
8. GRTSTERM	Once/Month (beginning)	Lists grants which will terminate at end of month.
9. ACPTLIST	As needed	Generates list of Korean Conference acceptors by country, region, expertise, role at conference, arrival and departure date.

In addition, we have capability of developing programs as requests for information are received.

In 1979, the computerization process will be focused on two main ideas:

- a. creation of new files, and b. development of computer applications and special reports for all of IPAVS' functional areas.

New files to be created include, but are not restricted to the following:

- a. SITE VISIT INFORMATION FILE: to include basic information on site visits such as name of visitor, dates of visit, and type of visit;
- b. CONSULTANTS FILE: to list individuals available to IPAVS for technical consultation, their areas of expertise, experience and other pertinent facts.
- c. COMMUNICATIONS FILE: to contain mailing list information, telephone numbers, cable and telex addresses, and other data.

Other files will be created as the need arises.

There are many areas in which the computer can be utilized, and a major task in the coming year will be to develop these areas. For example, a computer monitoring system can be developed for better management of equipment transactions, for fund transfer and audit

status monitoring, and for program evaluation using the revised reporting forms developed during 1978. The computer monitoring system should be able to identify problem areas more quickly, thus allowing the Grants Monitor to work more closely with staff to ensure timely follow-up action. The Grants Operations section will be in tune with program developments not only on a grant-by-grant basis but also on a country-wide or regional basis.

Additional work also remains to be done in the development of standard programs to access information frequently requested by staff and to present this information in a format that is clear and readable to individuals with no computer background. When this report-formatting work has been accomplished, it will be possible to replace the conventional registers used by various offices (e.g., sub-grants, small grants,) by computer printouts which can be updated easily and often. Much more information can then be produced in a form helpful to management and decision-making.

Much data is stored in the computer in more than one file. A project for 1979 will be to develop a system checking all data items to verify that information already stored in the computer is consistent from file to file.

An important part of the management of the computer system will be the development of a Procedures Manual to give details of the day-to-day running of the system. A technical section will give details of machine operations for the programming assistant responsible for daily input of data. A more general section will give details of use for the staff member who may want to use the computer and needs to understand possible applications.

The data management office will work closely with all staff to help them understand how the computer functions. It is hoped they will

then offer their own ideas for computer applications, and the computer will be of service to the fullest extent possible.

Project Monitoring System

The Projects Monitoring System was implemented in 1977 to assist IPAVS program staff to systematically identify incomplete sub-grant activities and problems and to trigger appropriate follow-up action. The basic system is structured around a series of standard "critical dates" in the life cycle of each project; for example, the dates of funder approval, receipt of signed documents, receipt of first fund transfer, and receipt of all budgeted equipment. There are approximately 21 critical dates. A schedule was designed to set a standard for the amount of time which should elapse between each event in the life cycle of a project. Actual completion dates are continually recorded and time lapses are checked periodically. When any activity has not been accomplished according to the pre-established schedule, the Projects Monitor marks it for further follow-up action and informs appropriate staff. In addition to this basic system, the Projects Monitor is responsible for monitoring follow-up actions taken as a result of trip reports; for recording, acknowledging, and monitoring the receipt of required reports submitted by sub-grantees; and for producing special reports on the efficiency of sub-grant support activities for use in management decision-making.

After installation of the computer, the Projects Monitor was able to begin computerization of basic monitoring information. As more computer files are created, including sub-grantees' reporting status and basic trip information, it will enable IPAVS to verify information and to keep program staff informed of areas in need of follow-up action. The computer will allow more rapid production of monitoring reports.

Sub-Grant Reporting

Upon approval of a proposal for funding, routine reporting requirements are established for the new sub-grant. Copies of standard reporting forms and the reporting schedule are sent to the sub-grantee along with the sub-grant document. Reports which may be required are as follows:

1. Statistical Reports on Sterilization Procedures and Complications, giving age, parity and numbers of acceptors of each procedure, and the nature, treatment and outcome of any major complications which may have occurred;
2. Progress Reports, providing narrative accounts of the progress and problems of each sub-grantee;
3. Equipment Problem/Status Report, describing the condition of and problems encountered with equipment provided to the sub-grantee;
4. Financial Report, furnishing information on budget expenditures to date, and cash on hand;
5. Repair Summary/Work Report, recording emergency repair and preventive maintenance work/visits by sub-grantee; and
6. Trainee Record Forms, evaluating the performance and capability of physician and health support staff trainees.

These are routine reports required of each sub-grant according to its programmatic emphasis. Some reports are due quarterly, others semi-annually; the financial reports can be submitted as frequently as once a month if necessary for reimbursement.

In addition to the routine reports, sub-grantees may be required to submit certain special reports less frequently, usually on an annual or semi-annual basis. Some examples of these special reports are the following:

1. Activity Plan, specifying how and when objectives will be accomplished (usually for NAVS grants);
2. Training Curriculum, outlining the practical and theoretical content and schedule of training courses;

3. Equipment Receiving Report, sent to IPAVS upon receipt of equipment; and
4. Special Study Report, giving results of any special surveys conducted by the sub-grantee.

This reporting system continues to provide IPAVS with needed information on the progress of sub-grantees toward reaching their goals.

During 1978, IPAVS's reporting forms were reviewed and revised to make them easier for sub-grantees to complete, to elicit pertinent information in a concise manner, and to enable IPAVS to be more responsive to sub-grantees' needs in the field. In addition, many of the revised forms are pre-coded, which will enable comprehensive computerized analysis of trends in the provision of voluntary sterilization services.

In 1978, the IPAVS reporting system monitored the receipt of reports from 129 sub-grants. Of these 129 sub-grants, 117 were required to submit reports during 1978. Only 4.3% of the 117 did not submit reports, an excellent overall reporting rate of 95.7%.

SUB-GRANT FINANCIAL REPORTING

IPAVS sub-grantees are still required to submit detailed financial reports at least four times a year on a calendar quarter basis. The financial report form has recently been modified by IPAVS to make it simpler and clearer for sub-grantees to understand and to use.

The IPAVS Financial Office continually updates its financial records as financial reports are received from sub-grantees for proper control and monitoring of financial status of each sub-grant. The newly installed IPAVS computer is proving to be an invaluable help in monitoring the financial situations of our sub-grants.

AUDITS OF SUB-GRANTS

IPAVS has an ongoing policy of having all sub-grants audited at the end of each sub-grant period. The audit is conducted by an independent accounting firm, selected by IPAVS, but located in the sub-grantee's country.

A total of 29 sub-grants in 15 countries were audited by IPAVS designated auditors during 1978. The audit program and audit report requirements were recently modified by IPAVS in order that additional information, both programmatic and financial, may be secured from the audited sub-grants. Whenever discrepancies or irregularities are detected from the audit reports, the IPAVS Financial Office communicates with the sub-grantees immediately and warns them of possible sanctions if such discrepancies or irregularities are not corrected. In addition, technical assistance is provided by staff when site visits are conducted. On the whole, the audit reports indicated that IPAVS sub-grantees are in compliance with the sub-grant contractual provisions.

Site Visits

Site visits serve to strengthen IPAVS's knowledge and understanding of sub-grantees' proposals, programs and progress, and to allow staff to offer direct and immediate assistance when needed. As such, site visits are indeed a valuable tool in the IPAVS management system. Visits are made for three basic purposes:

Initial - Conducted shortly before or after the award of a sub-grant to inspect project facilities, establish rapport between project staff and IPAVS and to review the project's overall design.

Technical Assistance - To assess sub-grant programs and to provide sub-grantees with advice and expertise to resolve problems, develop specific program components, or to work with them in developing organizational

and administrative details.

Medical - To ensure that sub-grantees are performing sterilizations according to good medical practice and to evaluate the adequacy of physician and para-medical training activities and facilities.

In 1978, 11 IPAVS staff members traveled to 45 countries. Current sub-grants were visited in 24 of these countries. An additional 21 countries were visited to establish future contacts, assess the need for IPAVS assistance, attend conferences and coordination meetings with other health and family planning organizations, and work on proposal development with potential sub-grantees. A total of 165 visits were made to 19 sub-grants and 35 potential sub-grants, for a total of 545 working days in the field. Appendix F contains a list of site visits made in 1978.

**APPENDIX A: Sub-Grants Awarded from January 1, 1978 - December 31, 1978,
by Dollar Amount, Major Programmatic Emphasis, Program Components
and Funding Components**

Key: A = Administration
E = Equipment
I = Information and Education
M = Maintenance and Repair
N = National Association related
O = Operational Expenses
P = Personnel
R = Renovation
S = Service
T = Training
U = Special Study

Country	Grant Number	Budget Total	Major Programmatic Emphasis	Program Components	Funding Components
Bangladesh	062-049-4N	\$ 54,157	N	N,A,	P,O
Bangladesh	062-049-4S	223,814	S	S,T,E,I,N	P,T,S,I,O,E
Bangladesh	185-049-2S-01	47,076	S	S,I,A,N	P,S,R,I,E,O
Bangladesh	193-049-2S-02	48,677	S	S,I,N,E	P,S,I,E,O
Bangladesh	249-049-1S-05	25,786	S	S,I,N,E,	P,S,I,E,O
Brazil	094-070-P3	32,000	T	T,S,E	P,T,R,E
Chile	048-080-3	7,585	S	S,U	P,S,I,E
Chile	055-082-3	13,455	S	S,T,I	P,T,S,I,E
Chile	207-150-P1	13,098	S	S,T,I,E	P,T,E
Egypt	070-057-3N	95,150	N	N,I,A,	P,I,O
Egypt	073-130-1	31,072	S	T,S,I	P,S,I,E,O
Egypt	194-147-1	11,057	S	S,E,I	P,S,I,E,O
Egypt	226-148-1	36,785	T	S,T,E,I	P,E,O
Egypt	255-057-1EM	2,546	M	M,N	P,O

Continued

Country	Grant Number	Budget Total	Major Programmatic Emphasis	Program Components	Funding Components
El Salvador	035-034-2	\$ 14,099	S	S,I,E	P,S,R,I,E,O
El Salvador	165-105-2	59,649	S	S,I,E	P,S,R,Z
El Salvador	197-121-1	213,512	E	E	E
Guatemala	156-109-2	510,208	S	S,T,I	P,T,S,R,I,E,O
Honduras	106-112-2	59,068	S	S,T,I,E	P,T,S,E,O
Honduras	251-143-1	27,605	A	A,I	P,I,O
Indonesia	075-053-3	76,902	S	S,T,I,E	P,T,S,I,E,O
Indonesia	225-062-1E	190,287	E	E	E
Iran	227-146-1	62,713	S	S,I,E	P,I,E,O
Jamaica	259-149-1	58,514	E	E	E
Korea	072-084-3	22,000	S	S,T,I	P,T,S,I,O
Korea	082-055-4N	50,635	N	I,N,A,U	P,I,O
Korea	124-086-3	17,540	S	S,T,I	P,I,O
Korea	196-055-1T	44,191	T	T,N,E,S	T,S,E,O
Korea	198-055-1S	21,410	S	N,S	S,O
Korea	210-055-1S	16,800	S	S,N	S,E
Korea	211-055-1T	23,730	T	S,T,E,N	T,S,E,O
Lebanon	252-144-1	37,347	S	S,T,I	P,I,E,O
Mexico	167-098-2	16,200	S	S,T	P,S
Mexico	244-139-1	145,016	M	M,E	P,O
Mexico	248-142-1	45,030	S	S,I,E	P,S,R,I,E,O

Continued

Country	Grant Number	Budget Total	Major Programmatic Emphasis	Program Components	Funding Components
Nicaragua	262-152-1	\$ 107,398	S	S	P,S,R,I,E,O
Nicaragua	267-151-1	34,215	S	S,T,E,I	P,R,I,E,O
Philippines	020-021-4	16,514	S	S,I	P,S,I,O
Philippines	101-068-3	40,368	S	S	P,E,O
Philippines	104-065-3N	26,537	N	N,A	P,I,O
Philippines	178-116-2	33,987	S	S,E,I	P,S,I,E,O
Sri Lanka	103-124-2N	18,600	N	N,I,A	P,I,O
St. Lucia	164-106-2	26,560	S	S,I	P,I
Sudan	155-123-2N	29,880	N	I,N,A,U	F,E,O
Taiwan	079-048-P5N	10,000	N	N,I,A	P,I
Thailand	026-042-4	46,200	S	S	P,S,E,O
Thailand	149-096-2N	51,554	N	N,A	P,S,I,O
Thailand	150-096-1S	6,666	S	N,I,S	P,E,O
Thailand	220-096-1EM	51,350	M	M,N,E	P,R,E,O
Tunisia	280-153-1	38,232	M	M,E	P,R,O
Turkey	024-037-3	10,475	S	S,T,I	P,S,I,E
Turkey	077-059-3N	12,000	N	N,I,A	P,I

Appendix B: Small Grants Awarded, Calendar Year 1978

Small Grant Number	Individual(s)	Institution	Country	Purpose
S-173	Dr. Bandes	ADN	Nicaragua	Films
S-174	Mr. Carlos Ariel Mr. Serapio Avila	Honduran Family Planning Association	Honduras	Training in laparoscope maintenance and repair
S-175	Dr. Rodolfo Quinones	SSA	Mexico	5 Verres needles
S-176	Dr. Diop	Hospital H. Lubke	Senegal	Laparoscopy training (falope ring)
S-177	Mr. Ernesto Perea Mr. Raphael Vara		Mexico	KLI training 2.6-10.78
S-178	Mr. Atiqur Rahman Khan	Asia Foundation	Bangladesh	1 slide projector
S-179	Dr. Lacayo	INSS	Nicaragua	Pad for stretcher
S-180	Dr. Fathalla	EFCS	Egypt	Travel and per diem to FIGO board meeting (California)
S-181	Dr. McDaniel	McCormick Hospital	Thailand	Travel to Colombo, Sri Lanka to attend FPA conference
S-182	Dr. Lacayo	INSS	Nicaragua	Assorted spare parts
S-183	Dr. Enrico Henriquez	Ministry of Health	El Salvador	Training MD's in laparoscopy and mini-lap (consultant)
S-184	Dr. Kisnisci	Turkish Fertility and Infertility Association	Turkey	Films and projectors

Small Grant Number	Individual(s)	Institution	Country	Purpose
S-185	Dr. Quinones	SSA	Mexico	Gynny Pelvic Model
S-186	Dr. Hee Yong Lee	KAVS	Korea	Films
S-187	Dr. Kang	Ewha Women's University Hospital	Korea	Projectors and films
S-188	Ms. Siti Bardatun Mr. Hun-inn Chiang	PUSSI AVS/ROC	Indonesia Taiwan	Technician training at KLI
S-189	Dr. Setna	Lady Dufferin Hospital	Pakistan	Spare parts
S-190	Mr. Rafael Vara	PIACT	Mexico	Travel and per diem to El Salvador and Guatemala (visit RAM center)
*S-192	Dr. Ramon Portes Carrasco	CONAPOFA	Dominican Republic	Yoon rings
S-193	Dr. Likeman	Modang General Hospital	Papua, New Guinea	6 mini-lap kits
*S-195	Dona Luz Pineda de Clare	Asociacion Hondurena de Planificacion de Familia	Honduras	Travel to Guatemala to observe administration of APROFAM Clinic
S-196	Dr. Daw Khin Kyi	Women's and Children's Hospital	Burma	System A Fertility Control Unit
S-197	Dr. Mohammed Boukhris	Ariana Clinic	Tunisia	Travel and per diem to Rabat, Morocco, May 21-24, 1978
S-198	Dr. Suporn Silpisornkosal	Chiangmai Hospital	Thailand	Teaching attachment
S-199	Dr. Galich	APROFAM	Guatemala	Laparoscopic equipment analyzer

* Small grants S-191 and S-194 were cancelled

Small Grant Number	Individual(s)	Institution	Country	Purpose
S-200	Sr. Luis Ernesto Rivera	Ministry of Health Maintenance Department	El Salvador	Travel to Guatemala to give TA to APROFAM RAM Center
S-201	Dr. Lacayo	INSS	Nicaragua	1,800 Yoon rings
S-202	Dr. Shelley Jubhari	Pelamonia Teaching Hospital	Indonesia	Falope-ring applicator and Yoon rings
S-203	Dr. Singh	Family Planning Association of Nepal	Nepal	Surgeons' gloves
S-204	Dr. Galich	APROFAM	Guatemala	5,000 Yoon rings
S-205	Dr. Ahmed Fawzy Abdelsalam	Zagazig University	Egypt	Teaching attachment
S-206	Dr. Fawzy	Zagazig University	Egypt	Films
S-207	Mr. Sriburatham	Thai AVS	Thailand	Teaching attachment
S-208	Dr. M.M.R. Weerasinghe	FPA of Sri Lanka	Sri Lanka	Mini-lap training
S-209	Dr. Ali Kambal	Khartoum North Hospital	Sudan	TPD, vasectomy training in Philippines
S-210	Dr. Hafez Yousseff	FPA of Alexandria	Egypt	Soonawalla speculum
S-211	Dr. Ramon Portes Carrasco	CONAPOFA	Dominican Republic	2,500 Yoon rings
S-212	Dr. Lombardo Martinez		Nicaragua	Visit IPAVS
S-213	Dr. M. Haddad		Tunisia	Visit IPAVS
S-214	Dr. Budicno Wibowo	Klinik Raden Saleh	Indonesia	Spare parts

Small Grant Number	Individual(s)	Institution	Country	Purpose
S-215	Dr. Chaoui Dr. Benjilloun	Maternite de Rabat	Morocco	5 mini-lap kits
S-216	Dr. Dinah Dr. Aubee	Princess Christian Maternity Hospital	Sierra Leone	4 mini-lap kits
S-217	Dr. Klufio (6) Dr. Andan (3)	Korle-bu Hospital Police Hospital	Ghana	9 mini-lap kits
S-218	Dr. Boukhris	ONPFP	Tunisia	Yoon rings
S-219	Dr. Galich	APROFAM	Guatemala	1,000 Yoon rings
S-220	Mr. Rafael Vara (PIACT Equip. Tech.)	PIACT	Mexico	Travel and per diem (Mexico City to NYC)
S-221	Dr. Paulo Traiman	Faculty of Medicine Universidade Estadual Paulista "Julio de Mesquita Filho"	Brazil	3 mini-lap kits
S-222	Dr. Nasah Dr. Sende	Central Maternity of Yaounde	Cameroon	4 mini-lap kits
S-223	Dr. Edward Calero	Consultorio de la Mujer	Bolivia	10 hooks and elevators
S-224	Dr. Bah Dr. El Hadi	Maternite le Dantec	Senegal	2 mini-lap kits
S-225	Dr. Jimenez	Hospital "Carlos Andrade Marin"	Ecuador	1 colpotomy kit 1 mini-lap kit 1 hook and elevator

Small Grant Number	Individual(s)	Institution	Country	Purpose
S-226	Dr. Emilio Bandes Wagui	A.D.N.	Nicaragua	5 uterine manipulators, chrome silk catgut, Ambubag, 2 soap dispensers
S-227	Dr. Argueta Riva	A.D.S.	El Salvador (035-034-2)	1 soap dispenser
S-228	Dr. Jose Arturo Coto	Hospital de Maternidad	El Salvador (147-091-2)	25 soap dispensers 1 Sims speculum 1 guide kit 1 cleaning brush
S-229	Dr. Gustavo Alberto Argueta Riva	A.D.S.	El Salvador (165-105-2)	2 soap dispensers
S-230	Dr. Mauricio Dehais Contreras	I.S.S.S.	El Salvador (135-087-2)	Emergency equipment: Ambubag, Laryngoscope, Endotracheal Tubes
S-231	Dr. G.C. Bird	Port Moresby General Hospital	Papua New Guinea	Falope-ring applicator and Yoon rings
S-232	Dr. Joaquin Nunez	ASHONPLAFA	Honduras	Resuscitator, suction machine
S-233	Dr. Milcah Donton	Mindanao Sanitarium and Hospital	Philippines	Films
S-234	Mr. Abderrahmane Mansour Mr. Taleb Baccouche	ONPFP	Tunisia	KLI training
S-235	Dr. David Mora Cuevas	Municipal Clinic	Mexico	1 floor OR lamp, assorted surgical instruments
S-236	Dr. Carlos H. Bravo	Hospital Central No. 2	Peru	1 colpotomy kit 1 mini-lap kit 1 hook/elevator set

Small Grant Number	Individual(s)	Institution	Country	Purpose
S-237	Dr. Pramila David	Center for Population Concerns	India	1 System A Fertility Control Unit
S-238	Dr. S.C. Thomas	USAID/Embassy	Afghanistan	Expendable supplies for JH PIEGO program and 10 mini-lap kits
S-239	Dr. Mohamed Boukhris	El Ariana Clinic	Tunisia	10 Kocher forceps 20 Leriche forceps
S-240	Dr. Argueta Rivas	Clinica Santa Tecla	El Salvador	5 boxes Narcan (10 ampules per box)
S-241	Dr. Joaquin Nunez	ASHONPLAFA (HFPA)	Honduras	1,500 Yoon rings
S-242	Dr. Azizur Rahman	BAVS (062-049-4S)	Bangladesh	7 laryngoscopes and tubes 1 training aid
*S-244	Dr. R. Prajitno	Surabaya Training Center	Indonesia	1,000 Yoon rings
S-245	Dr. Vovor Dr. Hodonnu Dr. Mensah	Association Togolaise pour le Bien-Etre Familial	Togo	3 mini-lap kits
S-246	Dr. Roger J. DeSieben-thal	John F. Kennedy Memorial Medical Center	Liberia	1 vasectomy kit
S-247	Professor Malick Sangaret	Service de Gynecologie et d'Obstetrique de Cocody	Ivory Coast	3 mini-lap kits
S-248	Professor Mutatch Kayomto	Hopital Clinique Universitaire Mama Mobutu	Zaire	2 mini-lap kits
S-249	Dr. Edmond Nkongolo-Tshiunza	Hopital de Kirotshe	Zaire	2 mini-lap kits

* Small grant S-243 was cancelled

Small Grant Number	Individual(s)	Institution	Country	Purpose
S-250	Dr. Lee Isaac	Church Medical Association of Zambia	Zambia	1 mini-lap kit
S-251	Dr. T.K. Chatterjee	OB/GYN Department, University Teaching Hospital	Zambia	5 mini-lap kits 1 cassette tape recorder
S-252	Dr. S.S. Roy	OB/GYN Department, University Teaching Hospital	Zambia	1 mini-lap kit
S-253	Professor Sulaiman Sastrawinata	Padjadaran University, Hasan Sadikin Hospital	Indonesia	4 films
S-254	Dr. Kapagama	Hopital General	Zaire, Republic of	2 tubal ligation kits
S-255	Dr. Milton Nakamura	Pontifica Universidade Catolica de Campinas	Brazil	1 teaching attachment 1 OR table
S-256	Dr. Milton Nakamura	Pontifica Universidade Catolica de Campinas	Brazil	1 fertility control unit
S-257	Dr. Khalida Al-Kaisi	Yarmak Hospital	Iraq	4 mini-lap kits 500 Yoon rings
S-258	Dr. H. Hamdouch	Centre de Sante Maternite Rabat	Morocco	4 mini-lap kits
S-259	Dr. Jallah	Firestone Medical Center	Liberia	2 mini-lap kits
S-260	Dr. Emile Woods Dr. Flavius Akerele	John F. Kennedy Memorial Medical Center	Liberia	4 mini-lap kits

Small Grant Number	Individual(s)	Institution	Country	Purpose
S-261	Professor Abdellatie Chaoui	Maternite de Rabat	Morocco	5 mini-lap kits
S-262	Dr. Pramila David	Center for Population Concerns	India	4 mini-lap kits 4 vasectomy kits
S-263	Dr. Joaquin Nunez	ASHONPLAFA (Honduran F.P.A.)	Honduras	1 laparoscopic equipment analyzer, 5,000 Yoon rings
S-264	Ms. Amparo Vela Ms. Esperanza Delgado	Coordinacion de Planificacion Familiar	Mexico	Orientation visit to IPAVS, January 7-11, 1979
S-265	Dr. Abdul Rahman El Hadaya	Yemen Family Planning Association	Yemen Arab Republic	5 vasectomy kits
S-266	Dr. Arturo Coto	Maternity Hospital	El Salvador	1 floor OR lamp 1 sphygmomanometer 1 stethoscope
S-267	Dr. Bandes Wagui	A.D.N.	Nicaragua	18 Farabent retractors

APPENDIX C: Activities of National Associations Funded by IPAVS, 1978

CURRENT NAVS ACTIVITIES	Bangladesh	Egypt	France (private)	Indonesia	Korea	Philippines	Sri Lanka	Sudan	Taiwan	Thailand	Turkey	TOTAL COUNTRIES
Organizational development, strengthening of administration and management	x	x	x	x	x	x	x	x	x	x	x	11
Provision of technical assistance and expert advice on voluntary sterilization	x	x	x	x	x	x	x	x	x	x	x	11
Establishment of standards for voluntary sterilization service delivery and training	x	x		x	x	x	x	x		x		8
Promotion of legislation and national policies for voluntary sterilization	x	x	x	x	x		x	x	x	x	x	10
Coordination of voluntary sterilization activities among public and private agencies	x	x	x	x	x	x	x	x	x	x	x	11
Maintaining a register or list of physicians/clinics providing services	x	x	x	x	x	x	x	x	x			9
Research/investigation of medical and biomedical aspects of sterilization		x			x			x				3
Collection of socio-economic, legal and psychological data regarding sterilization	x		x	x		x			x	x		6
Provision of funding of voluntary sterilization services	x								x	x		3
Training of physicians in sterilization techniques	x	x		x	x			x	x			6
Training of paramedic/auxiliary voluntary sterilization support personnel (e.g., nurses, midwives, counselors, etc.)	x				x		x		x	x		5
Implementation of public information program	x	x				x	x	x	x	x		7
Development/distribution of professional educational materials	x	x	x	x	x	x	x	x	x	x	x	11
Holding of seminars/conferences to educate physicians, allied health personnel, and other professionals	x	x		x	x	x	x	x	x	x	x	10
Organization of library/resource centers	x	x	x	x	x	x	x	x	x	x	x	11
Provision of sterilization equipment to other institutions	x	x		x			x			x		6
Organization of voluntary sterilization equipment maintenance and repair center		x		x	x					x		4

		1972		1976		1975		1976		1977		1978	
		Locally Registered/ Approved Structures	Under Registration	Locally Registered/ Approved Structures	Under Registration	Locally Registered/ Approved Structures	Under Registration	Locally Registered/ Approved Structures	Under Registration	Locally Registered/ Approved Structures	Under Registration	Locally Registered/ Approved Structures	Under Registration
DEVELOPING COUNTRIES - AFRICA	USA			USA	Canada South Africa	USA South Africa	Australia France	USA South Africa France Australia		USA South Africa France Australia	Spain	Australia France Italy South Africa USA	Spain
					England			England		England (A)		England (A)	Netherlands
DEVELOPING COUNTRIES - ASIAN AMERICANS	Costa Rica	Bangladesh Egypt Iran Taiwan		Bangladesh Costa Rica Egypt Indonesia Pakistan	Colombia Indonesia Iran India Indonesia Japan Philippines Sri Lanka Sudan Taiwan Thailand Turkey	Bangladesh Costa Rica Egypt India Indonesia Iran Japan Pakistan Philippines Sri Lanka Sudan Thailand Turkey	Colombia Indonesia	Bangladesh COSTA RICA Egypt India Indonesia Iran Japan Pakistan Philippines Sri Lanka Sudan Taiwan Thailand Turkey	Brazil Mexico Panama	Bangladesh Egypt India Indonesia Japan Pakistan Philippines Sri Lanka Sudan Taiwan Thailand Turkey	Brazil Spain Taiwan Yemen Arab Republic	Bangladesh Egypt India Indonesia Japan Pakistan Philippines South Africa Sri Lanka Sudan Syria Taiwan Thailand Turkey Yemen Arab Republic	Brazil Kosovo Morocco Peru Taiwan Yemen Arab Republic
					ACIP		ACIP		ACIP Indonesia El Salvador Nepal	Colombia Indonesia El Salvador Guatemala Nicaragua	Jordan Nepal Iran	Colombia (A) Indonesia (A) El Salvador (A) Guatemala (A) Iran Nepal Nicaragua	Norway Iran Jordan Nicaragua Taiwan Singapore

- (A) = WFO membership
 (A) = Affiliate organization with the WFO
 • = WFO applicant
 • = Initial interest list
- = General American Association of Police Instructors

Appendix E

General Characteristics of Member Associations
to the World Federation of Associations for
Voluntary Sterilization (WFAVS), 1978

Name of Association	Date of WF Membership	Type of WF Membership	Number of Assoc. Members	Number of Assoc. Branches	Number of Assoc. Comm.	Amount of Assoc. Annual Dues (US\$)
<u>Australia</u> Australian Association for Voluntary Sterilization	January 1978	National Association -- Voting	32	0	1	\$50
<u>Bangladesh</u> Bangladesh Association for Voluntary Sterilization	April 1975	National Association -- Voting	48	18	6	\$ 1
<u>Colombia</u> Asociacion Pro-Bienestar de la Familia Colombiana	January 1978	Affiliate Association -- Voting	100	0	4	Unknown
<u>Egypt</u> Fertility Control Society of Egypt	April 1975	National Association -- Voting	85	0	5	\$ 3
<u>El Salvador</u> Asociacion Demografica Salvadorena	January 1978	Affiliate Association -- Voting	662	0	11	Unknown
<u>France</u> French National Association for the Study of Sterilization	January 1977	National Association -- Voting	200	0	1	\$22
<u>England</u> Vasectomy Advancement Society of Great Britain	January 1977	Affiliate Association -- Non-Voting	300	0	1	\$ 2
<u>Guatemala</u> Asociacion Pro-Bienestar de la Familia de Guatemala	January 1978	Affiliate Association -- Voting	240	0	5	Unknown
<u>Honduras</u> Asociacion Hondurena de Planificacion de Familia	January 1978	Affiliate Association -- Voting	206	0	4	Unknown
<u>India</u> National Association for Voluntary Sterilization of India	February 1976	National Association -- Voting	220	0	3	Unknown

Name of Association	Date of WF Membership	Type of WF Membership	Number of Assoc. Members	Number of Assoc. Branches	Number of Assoc. Comm.	Amount of Assoc. Annual Dues (US\$)
<u>Indonesia</u> Indonesian Society for Voluntary Sterilization	February 1976	National Association -- Voting	200	11	6	\$ 3
<u>Korea</u> Korean Association for Voluntary Sterilization	April 1975	National Association -- Voting	403	0	4	\$ 4
<u>Pakistan</u> Pakistan National Association for Voluntary Sterilization	April 1975	National Association -- Voting	200	0	2	\$ 5
<u>Philippines</u> Philippine Association for the Study of Sterilization	February 1976	National Association -- Voting	240	0	7	\$ 3
<u>South Africa</u> Cape Association for Voluntary Sterilization	January 1977	National Association -- Voting	32	0	1	Unknown
<u>Sri Lanka</u> Sri Lanka Association for Voluntary Sterilization	April 1975	National Association -- Voting	95	2	5	\$ 4
<u>Sudan</u> Sudan Fertility Control Association	February 1976	National Association -- Voting	72	0	2	\$ 2
<u>Taiwan</u> Association for Voluntary Sterilization of the Republic of China	January 1977	National Association -- Voting	3,276	0	2	\$ 1
<u>Thailand</u> Thailand Association for Voluntary Sterilization	February 1976	National Association -- Voting	364	0	3	\$ 2
<u>Turkey</u> Turkish National Fertility & Infertility Association	January 1977	National Association -- Voting	35	0	4	\$ 7

Name of Association	Date of WF Membership	Type of WF Membership	Number of Assoc. Members	Number of Assoc. Branches	Number of Assoc. Comm.	Amount of Assoc. Annual Dues (US\$)
<u>United States</u> Association for Voluntary Sterilization	April 1975	National Association -- Voting	5,800	0	5	\$15
<u>United States</u> Population Dynamics	January 1978	Associate -- Non-Voting	100	0	1	Unknown

APPENDIX F: Site Visits Made in 1978

Key to Type of Visit

I = Initial Visit
TA = Technical Assistance

M = Medical Assessment
C = Conference Attendance

Sub-Grant by Country	Trip Dates	Site Visitor(s)	Type of Visit
BANGLADESH			
062-049-3N (4N prop) BAVS	1. January 20 - February 4	C. Aguilleaume/ T. Jezowski	TA
	2. March 18-19	T. Jezowski	TA
	3. May 24 - June 1	T. Jezowski	TA
062-049-4N BAVS	September 6-27	J. Aubert/ T. Jezowski	TA
062-049-3S (4S prop) BAVS, Dacca and Tongi	1. January 20 - February 4	C. Aguilleaume/ T. Jezowski	TA
	2. May 24 - June 1	J. Aubert	M
062-049-4S BAVS, Dacca and Tongi	September 6-27	J. Aubert/ T. Jezowski	M, TA
062-049-3I BAVS	1. January 20 - February 4	C. Aguilleaume/ T. Jezowski	TA
	2. March 18-19	T. Jezowski	TA
	3. September 6-27	T. Jezowski	TA
185-049-1S-01 (2S as prop) BAVS, Pabna	January 20 - February 4	C. Aguilleaume/ T. Jezowski	TA
185-049-2S-01 BAVS, Pabna	September 6-27	J. Aubert/ T. Jezowski	M, TA
193-049-1S-02 (2S prop) BAVS, Rangpur	January 20 - February 4	C. Aguilleaume/ T. Jezowski	TA
193-049-2S-02 BAVS, Rangpur	September 6-27	J. Aubert/ T. Jezowski	M, TA
216-049-1S-03 BAVS, Noakhali	September 6-27	J. Aubert/ T. Jezowski	M, TA
217-049-1S-04 (2S prop) BAVS, Khuina	September 6-27	J. Aubert/ T. Jezowski	M, TA

Sub-Grant by Country	Trip Dates	Site Visitor(s)	Type of Visit
<u>BANGLADESH</u>			
249-049-1S-05 (as prop) BAVS, Faridpur	1. January 20 - February 4	C. Aguiillaume/ T. Jezowski	I
	2. September 6-27	J. Aubert/ T. Jezowski	M, TA
000-090-M9 (as prop) BAVS, Dacca	1. January 20 - February 4	T. Jezowski	TA
	2. March 18-19	T. Jezowski	TA
	3. September 6-27	T. Jezowski	TA
Proposal 200S BAVS, Dacca	1. January 20 - February 4	T. Jezowski	TA
	2. March 18-19	T. Jezowski	TA
	3. May 24 - June 1	T. Jezowski	TA
Proposal 249 BAVS, Faridpur	January 20 - February 4	C. Aguiillaume/ T. Jezowski	I
Proposal 253S(06) BAVS, Jessore	September 6-27	J. Aubert/ T. Jezowski	M, I
Proposal 260S(07) BAVS, Comilla	September 6-27	J. Aubert/ T. Jezowski	M, I
Proposal 261S(08) BAVS, Dinajpur	September 6-27	J. Aubert/ T. Jezowski	M, I
Proposal 263S(09) BAVS, Sylhet	January 20 - February 4	C. Aguiillaume/ T. Jezowski	I
Proposal 266S(10) BAVS, Kushtia	September 6-27	J. Aubert/ T. Jezowski	M, I
<u>BARBADOS</u>			
Proposal 251 Barbados Family Planning Association	March 15-16	T. Shapiro	I
<u>EGYPT</u>			
070-057-2N Egyptian Fertility (3N prop) Control Society	1. June 5-10	I. Lubell	TA
	2. June 23-29	J. Holfeld	TA
255-057-1EM Assiut University (RAM Center)	1. June 5-10	I. Lubell	TA
	2. June 23-29	J. Holfeld	TA

Sub-Grant by Country	Trip Dates	Site Visitor(s)	Type of Visit
<u>EGYPT</u>			
194-147-1 National Institute for Cardiac Diseases	June 5-10	I. Lubell	TA
Proposal 229 Dar Ismail Hospital	June 5-10	I. Lubell	TA
<u>EL SALVADOR</u>			
035-034-2 (as prop) Asociacion Demografica Salvadorena	1. February 27 - March 1	J. Aubert/ T. Shapiro	I
	2. May 22-27	P. Butta	TA
	3. July 26-31	J. Aubert/ T. Shapiro	M, TA
	4. September 26-29	P. Butta/ I. Lubell/ M. Schima	TA
	5. December 3-16	J. Aubert	TA
135-087-2 Instituto Salvadoreno del Seguro Social	1. February 27 - March 1	T. Shapiro	TA
	2. July 26-31	J. Aubert/ T. Shapiro	M, TA
147-091-2 Maternity Hospital (3rd year prop) (3rd year prop)	1. February 27 - March 1	T. Shapiro	TA
	2. July 26-31	J. Aubert/ T. Shapiro	M, TA
	3. December 3-16	J. Aubert	TA
165-105-1 (2nd year prop) ADS (2nd year prop)	1. May 21-25	I. Lubell	TA
	2. July 26-31	J. Aubert/ T. Shapiro	M, TA
177-107-2 ISSS	1. February 27 - March 1	T. Shapiro	TA
	2. July 26-31	J. Aubert	M
197-121-1 Maternity Hospital	1. February 27 - March 1	T. Shapiro	TA
	2. July 26-31	J. Aubert/ T. Shapiro	TA
Proposal 292 Ministry of Health	July 26-31	J. Aubert	M

Sub Grant by Country	Trip Dates	Site Visitor(s)	Type of Visit
<u>EL SALVADOR</u>			
Latin American Regional Conference	1. May 21-27	P. Butta/ I. Lubell/ M. Schima	I
	2. December 3-9	J. Aubert/ I. Lubell/ M. Schima	C
<u>FRANCE</u>			
202-127-PIN French Association for the Study of Sterilization	April 10	C. Aguilleaume	I
<u>GUATEMALA</u>			
156-109-2 APROFAM (3rd year prop)	1. March 2-6	T. Shapiro	TA
	2. March 13-14	M. Schima	TA
	3. August 11-17	T. Shapiro	TA
<u>HONDURAS</u>			
106-112-2 (3rd year prop) Honduran Family Planning Association (CMQ Hospital)	August 4-10	T. Shapiro	TA
180-114-1 HFFPA (2nd year prop) (Materno-Infantil Hospital)	1. March 7-9	T. Shapiro	TA
	2. August 4-10	T. Shapiro	TA
251-143-1 HFFPA (2nd year prop)	1. March 7-9	T. Shapiro	TA
	2. August 4-10	T. Shapiro	TA
Proposal 273 HFFPA (I&E)	August 4-10	T. Shapiro	TA
Proposal 279 HFFPA (RAM Center)	August 4-10	T. Shapiro	TA
Honduras Conference (as prop) (August 1978)	1. March 7-9	T. Shapiro	TA
	2. March 15-16	M. Schima	TA
	3. August 3-6	J. Aubert/ I. Lubell/ T. Shapiro	C
<u>INDIA</u>			
India Conference (Patna)	November 3-9	I. Lubell	C

Sub-Grant by Country	Trip Dates	Site Visitor(s)	Type of Visit
<u>INDONESIA</u>			
075-053-2 (3rd year prop) Dharma Dutta Foundation	March 20-31	T. Jezowski	TA
075-053-3 Dharma Dutta Foundation	September 6-17	R. Vogel	TA
078-062-2N Indonesian Society for Voluntary Sterilization (PUSSI) (3N prop)	1. March 20-31 2. September 7-17	T. Jezowski R. Vogel	TA TA
225-062-1E (as prop) PUSSI	1. March 20-31 2. September 6-17	T. Jezowski R. Vogel	TA TA
078-063-2EM PUSSI (3EM prop)	1. March 20-31 2. September 6-17	T. Jezowski R. Vogel	TA TA
221-134-1 Raden Saleh Clinic	March 20-31	T. Jezowski	TA
222-135-1 Dr. Soetomo Hospital	March 20-31	T. Jezowski	TA
223-136-1 Mangkuyudan Hospital	March 20-31	T. Jezowski	TA
<u>ITALY</u>			
Proposal 310PN ASSTER	November 10-12	I. Lubell	I
<u>JAMAICA</u>			
168-120-1 (2nd year prop) University of the West Indies	February 23-26	R. Hopper/ T. Shapiro	I
259-149-1 (as prop) University of the West Indies	February 23-26	R. Hopper/ I. Lubell/ T. Shapiro	I
<u>JORDAN</u>			
157-095-2 Jordan University Hospital	June 11-14	I. Lubell	TA

Sub-Grant by Country	Trip Dates	Site Visitor(s)	Type of Visit
<u>KOREA</u>			
082-055-3N (4N prop) KAVS	February 26 - March 8	J. Holfeld/ E. McGinn	TA
145-055-2EM (3EM prop) KAVS, RAM Center	February 26 - March 8	J. Holfeld/ E. McGinn	TA
196-055-IT KAVS	1. February 26 - March 8 2. April 1-6	J. Holfeld/ E. McGinn I. Lubell	I M, TA
211-055-IT KAVS	February 26 - March 8	J. Holfeld/ E. McGinn	I
117-073-2 (3rd year prop) Seagrave Memorial Hospital	February 26 - March 8	J. Holfeld/ E. McGinn	TA
072-084-3 Ewha Women's University Hospital	February 26 - March 8	J. Holfeld	TA
124-086-3 Yonsei University	February 26 - March 8	E. McGinn	TA
192-129-1 (2nd year prop) Kwangju Christian Hospital	February 26 - March 8	J. Holfeld/ E. McGinn	TA
Korea Conference	1. February 26 - March 8 2. April 1-6 3. April 5-9 4. October 13-19	J. Holfeld/ E. McGinn I. Lubell M. Schima M. Schima	TA TA TA TA
<u>LIBERIA</u>			
Proposal 311 JFK Maternity Hospital	October 10-13	C. Aguillette	I
<u>MAURITIUS</u>			
091-075-1 (expired) Family Planning Association of Mauritius	April 27-30	C. Aguillette	TA
091-075-2 (as prop) FPA of Mauritius	April 27-30	C. Aguillette	TA

Sub-Grant by Country	Trip Dates	Site Visitor(s)	Type of Visit
<u>MEXICO</u>			
167-098-2 Instituto Nacional de la Nutricion	September 20-25	P. Butta/ M. Schima	TA
166-115-P1 Asociacion Pro Salud Maternal	September 20-25	P. Butta/ M. Schima	TA
243-138-1 Instituto Mexicano del Seguro Social	September 20-25	P. Butta/ M. Schima	TA
244-139-1 (2nd year prop) PIACT	September 20-25	P. Butta/ M. Schima	TA
245-140-1 Secretaria de Salud y Asistencia	September 20-25	P. Butta/ M. Schima	TA
246-141-1 Instituto de Servicios y Seguros Sociales de Trabajadores del Estado	September 20-25	P. Butta/ M. Schima	TA
<u>NEPAL</u>			
090-060-3 Family Planning Association of Nepal (4th year prop) (4th year prop)	1. January 23-25	M. Schima	TA
	2. March 12-17	T. Jezowski	TA
	3. September 1-5	T. Jezowski	TA
Proposal 256 FPA of Nepal	1. January 23-25	M. Schima	TA
	2. March 12-17	T. Jezowski	TA
	3. September 1-5	T. Jezowski	TA
<u>NICARAGUA</u>			
121-093-1 (2nd year prop) Nicaraguan Social Security Institute	August 1-3	J. Aubert/ T. Shapiro	M, TA
181-108-2 (3rd year prop) Asociacion Demografica Nicaraguense	August 1-3	J. Aubert/ T. Shapiro	M, TA
267-151-1 (as prop) ADN (Valez Pais Hospital)	August 1-3	J. Aubert/ T. Shapiro	M, TA

Sub-Grant by Country	Trip Dates	Site Visitor(s)	Type of Visit
<u>NIGERIA</u>			
132-100-1 (2nd year prop) Ibadan College Hospital	1. May 11-13 2. September 23 - October 1	C. Aguiillaume C. Aguiillaume	TA TA
Proposal 173 Ile-Ife University	September 23 - October 1	C. Aguiillaume	TA
Proposal 272 University of Nigeria Teaching Hospital	September 23 - October 1	C. Aguiillaume	TA
Proposal 320 University College Hospital, Ibadan	September 23 - October 1	C. Aguiillaume	I
<u>PAKISTAN</u>			
052-043-3 Lady Dufferin Hospital	January 26 - February 1	M. Schima	TA
053-044-2 Lady Willingdon Hospital	January 26 - February 1	M. Schima	TA
097-071-2N PNAVS	January 26 - February 1	M. Schima	TA
195-071-1EM RAM Center	January 26 - February 1	M. Schima	TA
143-094-1 Mayo Hospital	January 26 February 1	M. Schima	TA
<u>PANAMA</u>			
204-128-1 Ministry of Health	March 13-14	T. Shapiro	TA
<u>PHILIPPINES</u>			
104-065-3N Philippine Association for the Study of Sterilization	March 9-15	J. Holfeld/ E. McGinn	TA
178-116-1 (2nd year prop) Children's Medical Center	March 9-15	E. McGinn	TA

Sub-Grant by Country	Trip Dates	Site Visitor(s)	Type of Visit
<u>PHILIPPINES</u>			
101-068-3 (as prop) Family Planning Association of the Philippines	March 9-15	J. Holfeld/ E. McGinn	TA
<u>ST. LUCIA</u>			
164-106-2 St. Lucia Family Planning Association	February 21-22	R. Hopper/ T. Shapiro	I
<u>SRI LANKA</u>			
103-124-1N SLAVS (2N prop)	1. February 5-10 2. August 25-30	T. Jezowski T. Jezowski	TA TA
186-125-1 Family Planning Association of Sri Lanka (2nd year prop)	1. February 5-10 2. March 23-28 3. August 25-30	T. Jezowski I. Lubell T. Jezowski	TA TA TA
Proposal 254S SLAVS, Kandy	1. February 5-10 2. August 25-30	T. Jezowski T. Jezowski	I TA
Proposal 256 SLAVS, Batticoloa	August 25-30	T. Jezowski	I
Sri Lanka Conference (June 1978)	March 23-28	I. Lubell	TA
<u>SUDAN</u>			
155-123-1N (2N prop) Sudan Fertility (2N prop) Control Association	1. April 17-20 2. June 30 - July 3	C. Aguiillaume J. Holfeld	TA TA
Proposal 278 Soba University Hospital	June 30 - July 3	J. Holfeld	TA
<u>THAILAND</u>			
026-042-3 (4th year prop) McCormick Hospital	January 11-27	I. Lubell	TA
169-103-1 Ramathibodi Hospital	September 18-21	R. Vogel	TA
149-096-2N (3N prop) Thai AVS	1. January 11-27 2. September 18-21	J. Holfeld/ T. Jezowski/ I. Lubell R. Vogel	TA TA

Sub-Grant by Country	Trip Dates	Site Visitor(s)	Type of Visit
<u>THAILAND</u>			
220-096-2EM Thai AVS (RAM Center)	1. January 11-27	J. Holfeld/ I. Lubell/ T. Jezowski	TA
	2. September 18-21	R. Vogel	TA
Proposal 286S Thai AVS	September 18-21	R. Vogel	I
Proposal 287I Thai AVS	September 18-21	R. Vogel	TA
Proposal 290I Thai AVS	September 18-21	R. Vogel	TA
Proposal 291T Thai AVS	September 18-21	R. Vogel	TA
<u>TOGO</u>			
Proposal 308 (I&E) Togolese Association for Family Welfare	October 2-6	C. Aguilleaume	I
<u>TRINIDAD and TOBAGO</u>			
014-017-3 Trinidad and Tobago Family Planning Association	February 18-20	R. Hopper/ T. Shapiro	TA
<u>TUNISIA</u>			
096-122-1 El Ariana Clinic (2nd year prop)	1. April 11-15	C. Aguilleaume/ M. Schima	TA
	2. September 9-16	T. Shapiro	TA
280-153-1 (as prop) National Office of Family Planning and Population (RAM Center)	1. April 11-15	C. Aguilleaume/ M. Schima	TA
	2. September 9-16	T. Shapiro	TA
Proposal 282S Tunisian AVS	September 9-16	T. Shapiro	I
Proposal 294 Regional ONPFP Facilities	April 11-15	C. Aguilleaume/ M. Schima	I

Sub-Grant by Country	Trip Dates	Site Visitor(s)	Type of Visit
<u>TURKEY</u>			
027-037-3 Hacettepe University	July 5-7	J. Holfeld	TA
070-059-2N (3N prop) Turkish Fertility and Infertility Association	July 5-7	J. Holfeld	TA
<u>ZAIRE</u>			
Proposal 293 Bukavu General Hospital	September 11-22	C. Aguiillaume	I
Proposal 316 Uzazi-Bora Center	September 11-22	C. Aguiillaume	I
Proposal 285 Naissances Desirables Centers for Fertility Management	September 11-22	C. Aguiillaume	I

Appendix G Actual Yearly Cost of Sperry Univac BC/7 Mini-Computer
for 1978 and Projected Yearly Cost for 1979

Actual Yearly Cost, 1978

Hardware (machine, parts, etc.)	\$ 11,076 ^a
Software (programs provided by Sperry Univac)	640 ^b
Maintenance/repair	1,620 ^c
Supplies (paper, ribbons, disks, etc.)	947
Consultancy and training	1,250
	<hr/>
TOTAL	\$ 15,533

Projected Yearly Cost, 1979

Hardware (machine, parts, etc.)	\$ 11,076 ^a
Software (programs provided by Sperry Univac)	640 ^b
Maintenance/repair	2,160
Supplies (paper, ribbons, disks, etc.)	533
Consultancy and training	1,700 ^d
Expansion of disk storage capacity	4,800 ^e
	<hr/>
TOTAL	\$ 20,909

^aTotal of \$33,228 amortized over three years

^bTotal of \$1,920 amortized over three years

^cNine months at \$180 per month

^dConsultancy for one day per month at \$100 per day; one training course in advanced Escort computer language at \$500

^eThis expansion will be needed during 1979 to ensure ease of data manipulation.

(1) GRANT MASTER FILE

1. IPAVS project number.
2. The rest of the project number.
3. The country in which grant is located.
4. The geographic region in which grant is located.
5. Address of the project.
6. The type of agency.
7. Ownership of the agency.
8. Date proposal is received.
9. Date proposal reviewed by staff.
10. Date proposal approved by International Committee.
11. Date proposal sent to AID for approval.
12. Date proposal approved by funders (in writing).
13. Category of the final funding (AID, private).
14. Date grant document was sent to sub-grantee.
15. Date grant contract was signed.
16. Date signed contract letter was received at IPAVS.
17. Effective date of grant.
18. Termination date of grant.
19. Total budget of grant.
20. Category of grant (standard, NAVS, NAVS branch, NAVS supplemental).
21. Various program components carried out under grant, not necessarily funded components (service, training, etc.).
22. Primary programmatic emphasis of sub-grant.
23. Secondary programmatic emphasis of sub-grant.
24. Institution (agency name).
25. The type of service offered.
26. The number of male procedures to be carried out under grant.
27. The number of female procedures to be carried out under grant.
28. The number of physicians to be trained under the grant.
29. The number of non-physician medical personnel to be trained under grant (nurses, midwives and physician assistants).
30. The type of medical training to be carried out.
31. The type of non-medical training to be carried out.
32. The type of equipment items requested in the proposal (medical and non-medical).
33. The name of the project director.
34. The name of the agency director.
35. Does the grant comply with informed consent requirements (yes, no)?
36. Is the agency involved in any abortion related activities (yes, no)?
37. Are other family planning services available (yes, no)?
38. Is the facility a free standing clinic (yes, no)?
39. Does agency receive funding from other sources (yes, no)?
40. What is the I/E target population? (general public, professionals, etc)?
41. In what kind of area is the facility located (rural, urban)?
42. What category does this record fall into (proposal, approved grant, expired grant, etc.)?
43. Is country an excess currency country (yes, no)?
44. Is renovation one of the budget lines (yes, no)?

(2) GRANT MONITOR FILE

1. IPAVS project number.
2. The rest of the project number.
3. Country in which grant is located.
4. Geographic region in which grant is located.
5. Effective date of grant.
6. Termination date of grant.
7. Operational date of grant.
8. Date of initial transfer of funds.
9. Date initial transfer received by sub-grantee.
10. The date all equipment items have been ordered.
11. Date all equipment items have been shipped.
12. Date all equipment items have been received by sub-grantee.
13. Number of times grant has been reviewed by staff.
14. Dates staff reviewed the grant.
15. Number of requests made to sub-grantee for a continuation proposal.
16. Date the continuation proposal was requested.
17. Date the continuation proposal was received by IPAVS.
18. Number of administrative extensions given to the grant.
19. Administrative extension dates.
20. Reason for the administrative extension (use remaining funds, accomplish objectives, delay in starting program, etc.).
21. Date audit was requested.
22. Date audit was received at IPAVS.
23. Date of financial closure.
24. Date of final letter.
25. Date grant file closed.

(3) FINANCIAL MASTER FILE

1. Geographic region in which grant is located.
2. Country in which grant is located.
3. IPAVS project number.
4. The rest of the project number.
5. Has the budget been amended (yes, no)?
6. Number of times the budget has been amended.
7. Has the budget been reallocated (yes, no)?
8. Number of times the budget has been reallocated.
9. Has there been any uncommitted balance (yes, no)?
10. Amount of the uncommitted balance.
11. Budget total.
12. Budget Salary Line.
13. Budget Training Line.
14. Budget IE - Equipment Line (NY).
15. Budget IE - Equipment Line (Local).
16. Budget IE - Other.
17. Budget Medical Equipment Line (NY).
18. Budget Medical Equipment Line (Local).
19. Budget Operational Travel Line.
20. Budget Operational Rent Line.
21. Budget Operational Utility Line.
22. Budget Operational Communication Line.
23. Budget Operational Office Equipment Line (NY).
24. Budget Operational Office Equipment Line (Local).
25. Budget Operational Other Line.
26. Budget Renovation Line.
27. Budget Service Line.
28. Budget Bookkeeping Line.
29. Budget Bank Charge Line.
30. Budget Other Line.
31. Number of financial periods covered to date.
32. Last date the financial report covered.
33. Total of advances made to date.
34. Cash on hand with the sub-grantee.
35. Expenditures Salary Line.
36. Expenditures Training Line.
37. Expenditures I/E Equipment Line (NY).
38. Expenditures I/E Equipment Local Line.
39. Expenditures I/E Other Line.
40. Expenditures Medical Equipment Line (NY).
41. Expenditures Medical Equipment Line (Local).
42. Expenditures Operational Line - Travel
43. Expenditures Operational Line - Rent
44. Expenditures Operational Line - Utility.
45. Expenditures Operational Line - Communication.
46. Expenditures Operational Line - Equipment (NY)
47. Expenditures Operational Line - Equipment (NY).
48. Expenditures Operational Line - Other.
49. Expenditures Renovation Line.
50. Expenditures Service Line.
51. Expenditures Bookkeeping Line.
52. Expenditures Bank Charge Line.
53. Expenditures Other Line.

(4) FINANCIAL MONITOR FILE

1. IPAVS project number.
2. The rest of the project number.
3. Country in which grant is located.
4. Geographic region in which grant is located.
5. Effective date of grant.
6. Official termination date of grant.
7. Operational date of grant.
8. Number of administrative extensions given to the grant.
9. Final termination date.
10. Number of financial reports submitted to IPAVS.
11. Last date the financial report covered.
12. Dates financial reports were received at IPAVS Financial Office.
13. Number of reimbursements sent to grantee.
14. Dates reimbursements were sent.
15. Dates sub-grantee received reimbursements.
16. Amount of reimbursements sent to sub-grantee.
17. The status of financial report submission (all received, some overdue).
18. Is the most recent report the final financial report (yes, no)?
19. Date audit was requested.
20. Number of follow-up letters sent to auditor.
21. Dates of the follow-up letters.
22. Date audit was initiated.
23. Date audit report was received at IPAVS.
24. Is the audit report acceptable (yes, no, code for problems)?
25. Date of the letter to sub-grantee to request more information.
26. Date of the letter to auditor to request more information.
27. Date IPAVS received responding letter from sub-grantee.
28. Date IPAVS received responding letter from auditor.
29. Financial file closure date.
30. Audit fee.
31. Date audit fee sent.
32. Date audit fee received.

(5) NAVS FILE

1. Development state of the association (initial dialogue, formed but not registered, etc.).
2. Type of organization (NAVS, Affiliate, etc.).
3. Organizational structure pertaining to vote (federated, one man/one vote, etc.).
4. Geographic region in which organization is located.
5. Country in which organization is located.
6. Full name of organization.
7. Full address of organization.
8. Telephone number.
9. Cable address.
10. Name of individual who is the key IPAVS contact for organization.
11. Name of Administrative Officer.
12. Job title of Administrative Officer.
13. Date constitution adopted.
14. Date organization was registered.
15. Agency with which organization is registered.
16. Date Affiliate Committee was formed.
17. Name and title of President or Chairman of organization.
18. First Vice-President of organization.
19. Second Vice-President of organization.
20. Secretary of organization.
21. Treasurer of organization.
22. Chairman of Sterilization Committee.
23. Number of paid staff.
24. Date of last annual meeting.
25. Date of last election of officers.
26. Date of next election of officers.
27. Annual dues in U.S. Dollars.
28. Number of members in organization.
29. Number of organization branches.
30. Number of seven committees.
31. Member of WPAVS (yes, no)?
32. Type of WPAVS membership (NAVS, Affiliate Committee, etc.).
33. Is this organization a voting member of WPAVS (yes, no)?
34. Date organization joined WPAVS.
35. Funding sources of organization.
36. IPAVS sub-grant number.
37. Starting and termination dates of current or last IP sub-grant.
38. Total budget of current IP sub-grant.
39. Total amount of IPAVS funds awarded to core organization to date.
40. Is an IP proposal pending (yes, no)?
41. Project numbers of up to six current NAVS supplemental sub-grants.
42. Total budget figures for up to six current NAVS supplemental sub-grants.
43. Cumulative dollar amount of supplemental grants.
44. Current activities of the association (listed in coded form).
45. Number of small grants ever awarded to NAVS core or supplemental sub-grants.
46. Total amount of small grant funding awarded to NAVS core or supplemental sub-grants.
47. Date NAVS proposal requested (date of letter).
48. Date NAVS proposal received in IPAVS office.
49. Date NAVS proposal sent to AID.

(6) EQUIPMENT FILE

1. IPAVS project number.
2. The rest of the project number.
3. The country in which grant is located.
4. The geographic region of the country in which the grant is located.
5. Purchase order number of the equipment item.
6. Equipment item code.
7. Unit price of the item.
8. Quantity of the item ordered.
9. Total price of the item ordered (UNITPRICxQUANTITY).
10. The date the item was ordered.
11. The source from which the item was ordered.
12. Date on which the ordered item will be available.
13. Shipping status (partial shipment-order complete partial shipment-order incomplete, etc.).
14. Date the item was shipped.
15. Receipt status (receipt partial-shipment complete, receipt partial-shipment incomplete, etc.).
16. Date the sub-grantee received the item.
17. Working condition of the equipment item upon receipt.
18. Is shipment or receipt partial (i.e., incomplete)?
19. Is it a small grant?

(7) SERVICE FILE

1. IPAVS project number.
2. The country in which grant is located.
3. The geographic region in which grant is located.
4. Input sequence number.
5. Year of the reporting period.
6. Calendar quarter of the reporting period.
7. Starting date of the reporting period.
8. Ending date of the reporting period.
9. Report covers procedures for which sex?
10. Number of vasectomies performed in reporting period.
11. Total mini-laparotomy post-partum ring procedures performed this period.
12. Total mini-laparotomy post-partum no-ring procedures performed this period.
13. Total mini-laparotomy interval ring procedures performed this period.
14. Total mini-laparotomy interval no-ring procedures performed this period.
15. Total mini-laparotomy no ring procedures performed this period.
16. Total mini-laparotomy ring procedures performed this period.
17. Total laparotomy post-partum ring procedures performed this period.
18. Total laparotomy post-partum no-ring procedures performed this period.
19. Total laparotomy interval ring procedures performed this period.
20. Total laparotomy interval no-ring procedures performed this period.
21. Total colpotomy ring procedures performed this period.
22. Total colpotomy no-ring procedures performed this period.
23. Total culdoscopy ring procedures performed this period.
24. Total culdoscopy no-ring procedures performed this period.
25. Total laparoscopy ring procedures performed this period.
26. Total laparoscopy no-ring procedures performed this period.
27. Total Pomeroy procedures performed this period.
28. Total other procedures performed this period.
29. Total procedures performed this period.
30. Variables (48 in all) giving the number of patients accepting a sterilization procedure who fall into the age categories of age 24 or under, 25-29, 30-34, 35-39, 40 or over, age unknown, and into the parity categories of no children, 1 child, 2 children, 3 children, 4 children, 5 children, 6 children or parity unknown.
31. Name of hospital, clinic reporting.

(8) TRAINEE FILE

1. IPAVS project number.
2. Country in which grant is located.
3. Country code.
4. Geographic region in which grant is located.
5. Input sequence number.
6. Trainee's full name, first name first.
7. Trainee's name, last name first.
8. Trainee's sex.
9. Trainee's birthdate.
10. Date first training period started.
11. Date first training period ended.
12. Trainee's institutional affiliation.
13. Type of area in which trainee will work (major urban center, small urban area, rural).
14. Is trainee first from area to offer service (yes, no)?
15. Do others in trainee's area provide this service (yes, no)?
16. Trainee's professional status (MD, RN, etc.).
17. Trainee's professional specialization (GP, OB/GYN, etc.).
18. Institution where trained.
19. City where training institution located.
20. Country where training institution located.
21. Instructor's name for first training period.
22. Was trainee taught laparotomy no-ring procedure (yes, no)?
23. Was trainee taught laparoscopy ring procedure (yes, no)?
24. Was trainee taught mini-laparotomy no-ring procedure (yes, no)?
25. Was trainee taught mini-laparotomy ring procedure (yes, no)?
26. Was trainee taught laparotomy post-partum procedure (yes, no)?
27. Was trainee taught laparotomy interval procedure (yes, no)?
28. Was trainee taught culdoscopy no-ring procedure (yes, no)?
29. Was trainee taught culdoscopy ring procedure (yes, no)?
30. Was trainee taught colpotomy no-ring procedure (yes, no)?
31. Was trainee taught colpotomy ring procedure (yes, no)?
32. Was trainee taught other abdominal procedure (yes, no)?
33. Was trainee taught other vaginal procedure (yes, no)?
34. Was trainee taught vasectomy procedure (yes, no)?
35. Instructor's evaluation of trainee (outstanding, good, poor).
36. Years of education of non-physician trainees.
37. Type of education of non-physician trainees.
38. Date second training period started.
39. Date second training period ended.
40. Instructor's name for second training period.
41. Procedures for which trainee did not perform the number required by IPAVS policy. (IPAVS requirements listed in coding manual under each procedure.)
42. Number of follow-up reports on trainees.

(9) SMALL GRANT FILE

1. IPAVS small grant number.
2. Country in which grant is located.
3. Geographic region in which grant is located.
4. Name and address of the agency to which small grant is awarded.
5. Name of addressee who receives shipment.
6. City in which small grant is located.
7. The date AID approved the grant, if required.
8. The date the grant file is opened.
9. Components of the grant.
10. Primary programmatic emphasis of grant.
11. List of items awarded.
12. Type of sterilization equipment provided by the grant.
13. Estimated cost of the grant.
14. Actual cost of the grant.
15. Code for current status of the grant (on hold, closed, etc.).
16. Explanation of the status of the grant.
17. Is information for this small grant incomplete or not available (yes, no)?

(10) CONFERENCE GRANT FILE

1. IPAVS conference grant number.
2. Country in which grant is located.
3. Agency to which grant is awarded.
4. Key contact individual.
5. City in which conference is held.
6. Country in which the conference is held.
7. Geographic region in which the conference is held.
8. Date AID approved the grant.
9. Date document (contract) sent to sub-grantee.
10. Date sub-grantee signed the contract.
11. Date IPAVS received the signed contract.
12. Date the contract became effective.
13. Date the contract terminated.
14. Title of the conference.
15. Starting date of the conference.
16. Ending date of the conference.
17. Funding source of the grant (AID, private).
18. The scope of the conference (national, regional, etc.).
19. Components of the grant (contract, travel, per diem, etc.).
20. Number of participants.
21. Categorical breakdown of participants (MDs, government officials, etc.).
22. Is there a list of participants in the office (yes--in conference file; yes--in library; no)?
23. Main emphasis of the conference (technical aspects of VS, program administration, annual meeting, etc.).
24. Total budget.
25. Main sponsor of the conference.
26. Co-sponsors of this conference.
27. Date of first transfer of funds.
28. Date sub-grantee received first transfer of funds.
29. Date of second transfer of funds.
30. Date sub-grantee received second transfer of funds.
31. Type(s) of materials sent to sub-grantee.
32. Date materials ordered.
33. Date materials shipped.
34. Date sub-grantee received materials.
35. Reporting requirements.
36. Due date(s) of progress report(s).
37. Date(s) IPAVS received progress report(s).
38. Due date of financial report.
39. Date IPAVS received financial report.
40. Date IPAVS received report of proceedings.
41. Are travel arrangements completed (yes, no)?
42. Per diem transactions completed (yes, no)?

(11) KOREAN CONFERENCE FI

1. Name of invitee, last name first.
2. Name of invitee, first name first.
3. Invitee's title/agency affiliation.
4. Invitee's area of expertise.
5. Type of agency with which invitee is affiliated (university, hospital, family planning association, etc.).
6. Invitee's address.
7. Invitee's city.
8. Invitee's country.
9. IPAVS Country Code.
10. Geographic region of invitee.
11. Invitee's office telephone number.
12. Invitee's home telephone number.
13. Telex number of invitee.
14. Cable address of invitee.
15. General invitee or program participant?
16. Plenary panel number.
17. Plenary panel role(s).
18. Task force number.
19. Task force role.
20. Date invitation sent (most recent).
21. Date invitation sent (most recent, in computer format).
22. Date reply received (most recent).
23. Date reply received (most recent, in computer format).
24. Invitee's reply.
25. Date advanced registration received (most recent).
26. Date advanced registration received (most recent, in computer format).
27. Date confirmation letter sent.
28. Date confirmation letter sent (in computer format).
29. Date of last follow-up letter.
30. Date of last follow-up letter (in computer format).
31. How is invitee funding travel to conference (IPAVS, self, other)?
32. Name, address of other agency funding invitee's travel.
33. Invitee's arrival date in Seoul.
34. Invitee's arrival date in Seoul (in computer format).
35. Invitee's departure date from Seoul.
36. Invitee's departure date from Seoul (in computer format).
37. Accommodations requested.
38. Is spouse accompanying invitee (yes, no)?
39. Is individual on an organization committee (yes, no)?
40. Title/Name of committee.
41. Committee role.

(12) REPORT MONITORING FILE (I)

1. IPAVS project number.
2. The rest of the project number.
3. Country in which grant is located.
4. Geographic region in which grant is located.
5. Annual reports required.
6. Quarterly or semi-annual reports required.
7. Due date of Activity Plan.
8. Date Activity Plan received at IPAVS.
9. Due date of Training Curriculum.
10. Date Training Curriculum received at IPAVS.
11. Due date of Evaluation Plan.
12. Date Evaluation Plan received at IPAVS.
13. Due date of I&E Plan.
14. Date I&E Plan received at IPAVS.
15. Due date of equipment Utilization Plan.
16. Date Equipment Utilization Plan received at IPAVS.
17. Due date of Study Plan.
18. Date Study Plan received at IPAVS.
19. Due date of published study.
20. Date copy of published study received at IPAVS.
21. Number of other reports required or requested.
22. Names of other reports required or requested.
23. Due dates of other required or requested reports.
24. Dates other reports received at IPAVS.
25. Number of progress reports received at IPAVS.
26. Number of progress reports now due at IPAVS.
27. Dates progress reports received at IPAVS.
28. Beginning dates of reporting periods for progress reports.
29. Ending dates of reporting periods for progress reports.
30. Number of equipment problem reports received at IPAVS.
31. Number of equipment problem reports now due at IPAVS.
32. Dates equipment problem reports received at IPAVS.
33. Beginning dates of reporting periods for equipment problem reports.
34. Ending dates of reporting periods for equipment problem reports.
35. Number of work reports/repair summaries received at IPAVS.
36. Number of work reports/repair summaries now due at IPAVS.
37. Dates work reports received at IPAVS.
38. Beginning dates of reporting periods for work reports.
39. Ending dates of reporting periods for work reports.
40. Name of other quarterly report required.
41. Number of this quarterly report received at IPAVS.
42. Number of this quarterly report now due at IPAVS.
43. Dates this quarterly report received at IPAVS.
44. Beginning dates of reporting periods for this quarterly report.
45. Ending dates of reporting periods for this quarterly report.
46. General comments regarding reporting status, including dates of reminders re overdue reports.

(13) REPORT MONITORING FILE (II)

1. IPAVS project number.
2. Country in which grant is located.
3. Number of statistical reports received at IPAVS.
4. Number of statistical reports now due at IPAVS.
5. Dates statistical reports received at IPAVS.
6. Beginning dates of reporting periods for statistical reports.
7. Ending dates of reporting periods for statistical reports.
8. Number of financial reports received at IPAVS.
9. Number of financial reports now due at IPAVS.
10. Dates financial reports received at IPAVS.
11. Beginning dates of reporting periods for financial reports.
12. Ending dates of reporting periods for financial reports.
13. Number of trainee record forms received to date at IPAVS.
14. Number of trainee record forms received for MDs.
15. Number of trainee record forms received for non-MDs.
16. Number of individuals trained to date.
17. Number of individual MDs trained to date.
18. Number of individual non-MDs trained to date.